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ABSTRACT

This report presents the analysis of a descriptive study of adolescents (n=590) at four Washington high schools who were assessed for substance abuse. Areas of concentration in evaluating referral processes are as follows: (1) general information regarding communication between school staff and Consultation Programs; process within the school to a substance abuse specialist; (3) the assessment process which occurs when students are "at risk"; (4) communication between the school and the treatment agency; (5) the re-entry of students to school and recovery support programs. The study concluded administrative support for prevention/intervention programs is of utmost importance. School counselors found school-based referral and treatment programs to be effective because of easy access to students and the comparative stability of the school in students lives. Checklists of student behavior patterns are the primary referral tool at each school. While the point of assessment varied among schools, the importance of having a stable referral and assessment process was emphasized. The majority of students in inpatient treatment returned to school, but continuous tracking records were not kept in any of the schools. (KM)

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ED 374 361

REPORT

# The Referral Process of School Intervention Programs in Washington State to Alcohol and Drug Assessment Centers

## A Case Study of Four High Schools

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# THE REFERRAL PROCESS OF SCHOOL INTERVENTION PROGRAMS IN WASHINGTON STATE TO ALCOHOL AND DRUG ASSESSMENT CENTERS

A Case Study of Four High Schools

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May 1992

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*We wish to thank the staff and administrators interviewed at the four schools in this study. With constant demands on their time, often with students at their door, they gave their time to answer the questions in a candid and often detailed manner. We are also indebted to the school district administrators for cooperating with us in this study. The Educational Service Districts' Substance Abuse Prevention/Intervention coordinators contacted provided us with the history of the school programs in their area. Additional information about assessment and treatment services available came from interviews with staff members at assessment and treatment agencies. We thank them for their time.*

*We also thank Carol Strong, supervisor of the Substance Abuse Prevention/ Intervention program for the Office of the Superintendent of Public Instruction (OSPI). Her work with the Adolescent Project Advisory Committee and her suggestions for the study are greatly appreciated. Additional suggestions came from other members of the Adolescent Project Advisory Committee on key people to interview and some topics to cover in the questionnaire. Special thanks to all members of the Committee for these suggestions, and for their selfless participation in meetings.*

*Special thanks go to the many people who reviewed the draft questionnaire; they included OSPI staff, school counselors, school board members, alcohol/drug treatment agency administrators and counselors, the Division of Alcohol and Substance Abuse (DASA) administrators, DASA regional administrators, and several ORDA colleagues. Sherry Hamilton helped in formatting the questionnaire.*

*Special recognition goes to all the project staff who contributed different tasks to this report. Bonnie Atkinson, Bevin Hansel and Jane Dillon-Wingfield created tables, and accomplished the report production. Gordon Whitlow aided in data input and analysis. The program for the data analysis was developed by Julie Jordan. Her suggestions in formatting the questionnaire to be "input friendly," greatly aided analysis. The creative work on the flow charts was done by Janet Mason and Julie Jordan. Lawrence Weisser of the Office of Financial Management helped with economic and population data. Dario Longhi, Ph.D., was helpful in focusing the research and clarifying the methods section. Thanks to all of them and to other colleagues who took time away from their own projects to review the questionnaire and draft report. Their edits and suggestions for tables and charts are highly valued.*

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# EXECUTIVE SUMMARY

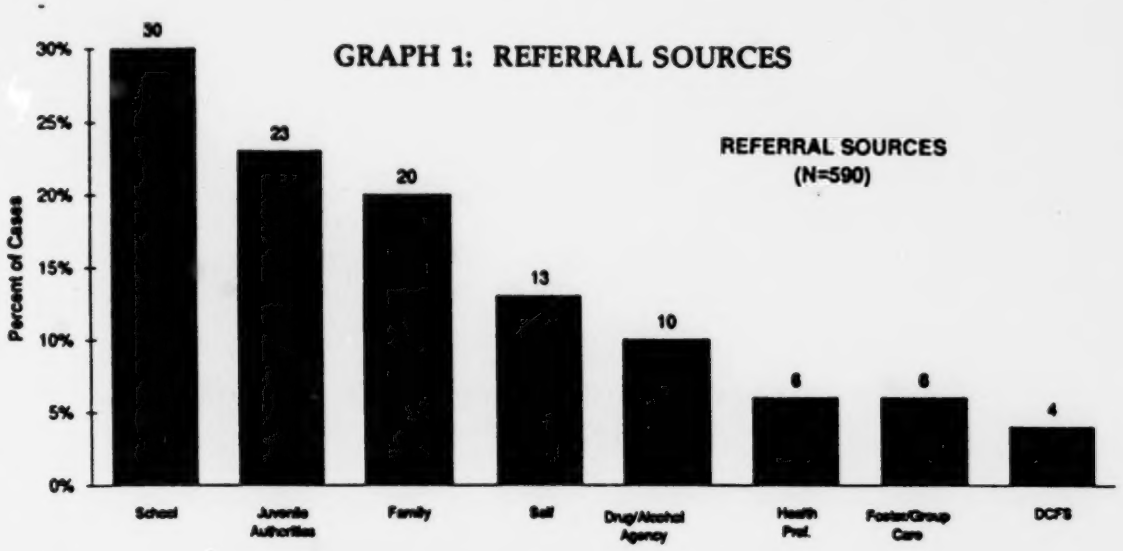
## BACKGROUND AND PURPOSE

Introduction

In 1989 the State Omnibus Alcohol and Controlled Substances Act (Omnibus Act) was passed, enabling many schools, for the first time, to establish intervention programs to provide services for students who are already involved with alcohol and/or other drugs. Grants from the Omnibus Act allowed schools to hire Substance Abuse Intervention Specialists (SAIS) and establish a comprehensive Student Assistance Program (SAP).

SAP's attempt to address some of the special needs of students related to problems of alcohol/drug (A/D) use. Some schools had begun implementing these programs in the early 1980s using their own resources.

The Office of Research and Data Analysis recently completed a descriptive study of adolescents assessed for substance abuse (Andris, et al., 1992). The study examined records of 590 such clients from around the state. The most frequent referral source reported was "school" (30%).




NOTE: An adolescent may be referred into treatment by more than one source. Consequently the percents add up to more than 100.
Source: Andris, et al., 1992, p. iii.

The relationship between school intervention programs and local assessment and treatment agencies is of interest to the Division of Alcohol and Substance Abuse (DASA) for many reasons. The School Case Study is part of the Adolescent Project, a study of adolescents and alcohol and drug treatment in Washington State.

## Purpose of the Study

The purpose of the School Case Study is to describe the referral process of intervention programs in four high schools and their relationships with local alcohol/drug assessment centers. These schools received Omnibus Drug funds, and reflect different staffing models for the intervention specialist.

## Staffing Models

Staffing models most commonly used by schools receiving Omnibus funds were identified. The supervisor of the Prevention/Intervention Substance Abuse program in the Office of the Superintendent of Public Instruction (OSPI) and alcohol/drug coordinators in some of the Educational Service Districts (ESD) suggested three schools representing these models. An alternative school was included in the study as a fourth model because of the special population such schools generally serve. The four staffing models selected for the study are:

**MODEL 1:** A Chemical Dependency Counselor hired by the school district to work as the SAIS.

**MODEL 2:** A school staff member with other duties designated as the SAIS; this person is not a Chemical Dependency Counselor.

**MODEL 3:** An agency Chemical Dependency Counselor contracted as the SAIS and works with the school Student Assistance Specialist (SAS).

**MODEL 4:** An agency Chemical Dependency Counselor contracted to be the SAIS at an alternative school.

## STUDY METHODS

Case Study

This report describes a case study. No hypothesis was tested. The cases studied do not represent a statistical or probability sample, nor are they comprehensive in scope. They were not intended to be representative of situations in other schools. Each case is looked at individually. Each school is unique in its population, community and staffing model.

All schools received Omnibus funds for the biennium 1989-1991. The funds for one school in the study were cut nearly in half in the current biennium, making responses variable depending on the particular year in question.

Descriptive Questions - Areas of Inquiry

Questions were asked of selected school and agency staff. In each school the principal or vice-principal, counselor and substance abuse intervention specialist (SAIS) was interviewed. A total of nineteen people were interviewed, three to six in any one school (see Appendix C).

Questions were asked concerning the usual procedures for adolescents' obtaining an alcohol/drug assessment, treatment, and then returning to school in each of the following five areas:

(1) General information regarding communication between the school staff and the local alcohol/drug assessment agency staff.

(2) The referral process, within the school, of a student to the Student Assistance Specialist (SAS) or to the Substance Abuse Intervention Specialist (SAIS).

(3) The assessment process which occurs when a student has been identified as "at risk" and in need of an assessment.

(4) The school and treatment agency's communication.

(5) The re-entry of students to school and recovery support programs.

## FINDINGS

Nearly all the non-administrators interviewed discussed the importance of administrative support for the prevention/intervention programs. The success of these programs, they stated, was dependent on the manner and support of the school administrators. The

administrator sets the attitude in the building and offers the budgetary support to core team members, counselors, and intervention specialists. The education of school staff about substance abuse issues is seen by the chemical dependency counselors' (CDC) interviewed as important to the school staff in being able to more accurately identify affected behavior of students.

School-based programs were seen as effective by the majority of those interviewed. Two reasons for this effectiveness that were mentioned by school counselors were the accessability of students in school and the comparative stability of the school in students' lives.

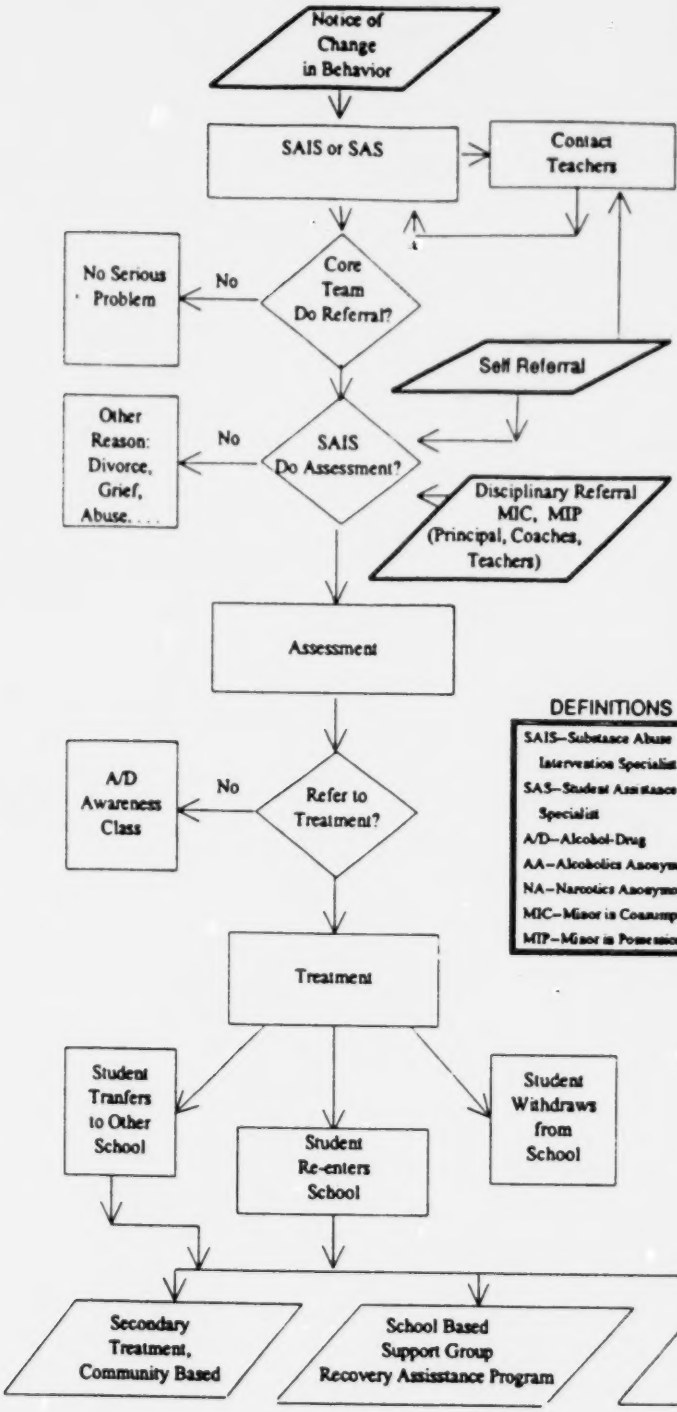
In interviews with staff at treatment centers and from the interviews in this study, a general pattern to the process of a student being referred to a SAIS, given an assessment, entering treatment then returning to school emerged. This is shown in Figure 1 on page v. (Flow charts relating to the specific staffing models are shown in their respective chapters.) General findings by specific areas of this process follow. Some of the characteristics of each of the four staffing model in the study are then listed.

Referrals: Some form of checklist detailing student behavior is the primary referral tool used in each school (see Appendix A). The majority of those interviewed indicated that education of teachers and other school staff about the signs and symptoms of chemical dependency seems to be the key to having teachers make sound referrals to the core team members. This education, and the priority given to it by the administration, was noted in each case to be the foundation for the referral process within the schools.

Assessments: The process of a student actually receiving an assessment was said, by most of those interviewed, to be facilitated by: a consistent referral method and process in place, the availability of an assessment or referral person on campus who is known by the student, a clear school policy regarding the use of A/D that is widely understood and enforced, and family support and encouragement. In the alternative school, assessments were given as part of the entrance requirement if the student had a history of a prior A/D assessment or treatment. This involved approximately ten percent of the population served.

Treatment: In Washington State, parent authorization is needed to place a minor in residential treatment. In this regard, parents play a key role in getting students to treatment. All those interviewed stated that the parents attitude towards and support of treatment was the deciding factor in the adolescent going to residential treatment. The CDC and the SAIS are the main contacts with treatment agencies and usually act as the liaison between treatment agencies and parents. The four CDC's interviewed, including one at the referral agency in case two, said that they made confidential referrals to outpatient treatment as necessary when no parent/guardian support was evident. [Washington State law (RCW 70.96A.095, 1989) allows adolescents fourteen years and older to obtain outpatient treatment for substance abuse without parental consent.] Results from this study indicate that there is little contact between other school

# Figure 1
## GENERIC REFERRAL SEQUENCE




**DEFINITIONS**

SAIS–Substance Abuse Intervention Specialist
SAS–Student Assistance Specialist
A/D–Alcohol-Drug
AA–Alcoholics Anonymous
NA–Narcotics Anonymous
MIC–Minor in Consumption
MIP–Minor in Possession

**REFERRAL**

Can be by any school or community person, parent or friend.

SAIS gathers data on student behavior from contact teachers. Usually a check list of behaviors is used.

Core Team discusses student and makes a decision regarding the student meeting with the SAIS.

Student is called in to discuss concerns with SAIS or SAS. A decision regarding an assessment is made.

**ASSESSMENT**

An assessment is done, on or off campus. Most school policies require an assessment as part of a disciplinary referral.

Assessment is evaluated and a treatment decision is made.

**TREATMENT**

Appropriate treatment is arranged for the student. Contact with school regarding referral issues, course work.

**RE-ENTRY**

Student re-enters school. Usually one meeting with a counselor beforehand to arrange for school work and assign to appropriate support group.

staff and treatment agency staff. The SAISs interviewed stated that more A/D education of school staff is needed, as well as time for school staff to be involved in the treatment plan of the student at the treatment agency.

Re-entry: Respondents interviewed were asked what percent of the students who left for inpatient treatment came back to the same school. The answers ranged from 70% to 100%. Assessment agency staff, having more direct contact with the students in treatment, more often stated 70% to 80%. Percents stated by school administrators were higher, as were the percentages stated by those interviewed in schools where there were few other options for the returning student, such as an alternative school or other high school in the area.

No specific records are kept tracking those students who have been in treatment in any of the schools studied. In all four schools aftercare programs like the Recovery Assistance Program: A Teacher's Guide to Drug and Alcohol Recovery Education (RAP), (Seattle-King County Department of Public Health (S-KCDPH), 1989), often provide the ongoing support needed after treatment. These aftercare programs are usually incorporated into for-credit classes, such as life skills or health and family life. Though most of those interviewed stated that the students returning from treatment continue with community-based treatment, where available, there was no monitoring by the school unless treatment compliance was a condition for attendance.

When asked about community-based aftercare treatment programs, most of those interviewed (except those who were not school counselors or chemical dependency counselors) referred to support groups such as the twelve step Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). This indicates a lack of understanding, by some school staff, of the difference between continuing treatment programs and support groups. In one school studied (case three), the chemical dependency counselor estimated that less than fifty percent of the students who had been in treatment participated in community-based aftercare of any sort.

## Characteristics of Each Staffing Model

Following is a brief description of each staffing model and the advantages and disadvantages of those models most often stated by the respondents at each school.

Model One: The substance abuse intervention specialist (SAIS), who is a CDC, is hired full-time by this rural school district. As there are no assessment or outpatient treatment agencies nearby, the SAIS does assessments on campus and makes most referrals to residential treatment centers. According to the SAIS, there was little success with outpatient referrals in the past due to distances to facilities and lack of transportation.

Advantages to this staffing model with a school-hired SAIS/CDC on campus are:

- That the assessment person was on staff, and available for emergencies,
- That the SAIS was able to develop a personal relationship and credibility with the staff, students, families, AA groups, and police, and
- That the staff had immediate access to information on prevention programs.

Disadvantages expressed are:

- That prevention/intervention program planning, staff and community education and other duties were a lot more work and more time consuming for the SAIS than just doing assessments.
- That no one else on the staff or in the community had the same training or background, so that professional peer consultation was not available.

The SAIS was the only one to express any disadvantages to this staffing model

Model Two: Full-time school staff with ongoing duties, who are not chemical dependency counselors, are designated as the SAIS at this school. Assessments are done off-campus at assessment/treatment agencies. Though a rural community with an agricultural economic base, it is within ten miles of a community ten times its size.

Advantages stated to this model are:

- That there is more privacy for student and family with the assessments at an agency instead of at school,
- That academics are separated from family dynamics and health care issues affected by substance abuse,
- That the family takes the responsibility for getting the assessment, and
- That the assessment/treatment agency has more information regarding treatment options and is seen as more professional regarding A/D issues than the school due to those resources available.

Disadvantages stated by those interviewed working in this model are:

- That transportation was not always available and assessment offices are four and seven miles away,

- That parent support was often not available, so many students just do not get their assessment done, and

- That assessment staff did not get to be known by students prior to the assessment.

Model Three: This large urban school has one of its counselors designated as the student assistance specialist (SAS) and carries out many of the duties of a substance abuse intervention specialist. A chemical dependency counselor (CDC) is contracted by the school district to do assessments.

Advantages stated by those interviewed to this staffing model are:

- That assessments are done on campus,

- That the SAS and CDC are available for self-referrals,

- That the school-contracted CDC serves as a link between schools in the district treatment centers and community programs, and

- That the school has more information on a student than an assessment agency off-campus.

Disadvantage of this model noted by the persons interviewed are:

- That the school-contracted CDC is at school for assessments only, time cut from last year, and is not available for core team meetings and aftercare groups so it takes longer to establish credibility and relationships with staff and students.

Model four: At an urban alternative school of less than 300, the school district contracts for the services of a CDC. At the school 75% of the time, the CDC administers assessments to those enrolling with a prior history of an A/D assessment or treatment, coordinates prevention/intervention programs and works with the staff in student support groups.

Advantages stated for this staffing model are:

- That assessments are done on campus, and

- That the entire staff is involved in student advocacy programs adds support to the school-contracted CDC and builds trust among staff and students.

Disadvantages stated for this staffing model are:

- That the program is easily affected by budget cuts as the program is primarily funded by state rather than local school district money. The CDC was at school only 75% to 80% of the time, reduced from 100% the prior year, so that continuity of programs is difficult.

**Limitations**

There were only four schools in this study, each representing a particular staffing model in its intervention program. A limited number of staff were interviewed, primarily those directly involved in the referral process. It is not within the scope or purpose of this study to compare one model of staffing with the other, though common factors are noted.

The schools in the study were selected because of their ongoing programs and supportive staff. Even so, staff turnover in the schools and in the assessment agencies added to the lack of knowledge of program history by some of the participants. Adolescent chemical dependency counseling is a relatively new field. Many A/D counselors intern for their two thousand hours of supervised training and then move to a different organization for additional experience. In schools, program funding is not always consistent from year to year. There are staff changes as people look for permanent positions.

Schools in this study may not be typical in the reported good or very good relationships with treatment centers. In another part of the Adolescent Project, the "Program Descriptive Study" (Louden, 1992), relationships between treatment centers and schools were not always stated as positive.

The schools in this study are each in the third year of receiving Omnibus Drug funds. All four schools have had Student Assistance Programs, utilizing core teams or similar programs, for several years. According to treatment agency staff and ESD personnel interviewed, the schools in this study are reputed to have strong and established programs in chemical dependency intervention as represented by their dedicated staff and administration.

# CHAPTER 1: INTRODUCTION

## BACKGROUND AND LEGISLATION

### Office of the Superintendent of Public Instruction

The 1989 Legislature passed the Omnibus Alcohol and Controlled Substances Act (Omnibus Act) providing funding for Prevention and Early Intervention Programs. These funds were distributed to school districts by the Office of Superintendent of Public Instruction (OSPI) via a grant process.

It was legislative intent to fund 80% of local school district and/or consortia projects in order to: "... establish, expand, or enhance programs and activities dedicated to prevention and intervention services provided to students and their families; assist in referrals to treatment providers; and strengthen the transition back to school for students who have had problems of alcohol and other drug abuse" (OSPI Bulletin No. 8-89).

Some schools had begun implementing Student Assistant Programs (SAPs) in the early 1980s using their own resources. The Omnibus grants, however, enabled many schools, for the first time, to hire intervention specialists and establish a comprehensive SAP.

Some of the activities a comprehensive SAP can offer include:

(1) Individual and family counseling, including preventive counseling,

(2) Assessment and referral for treatment,

(3) Aftercare,

(4) Staff training, and

(5) Development and coordination of "core" teams.

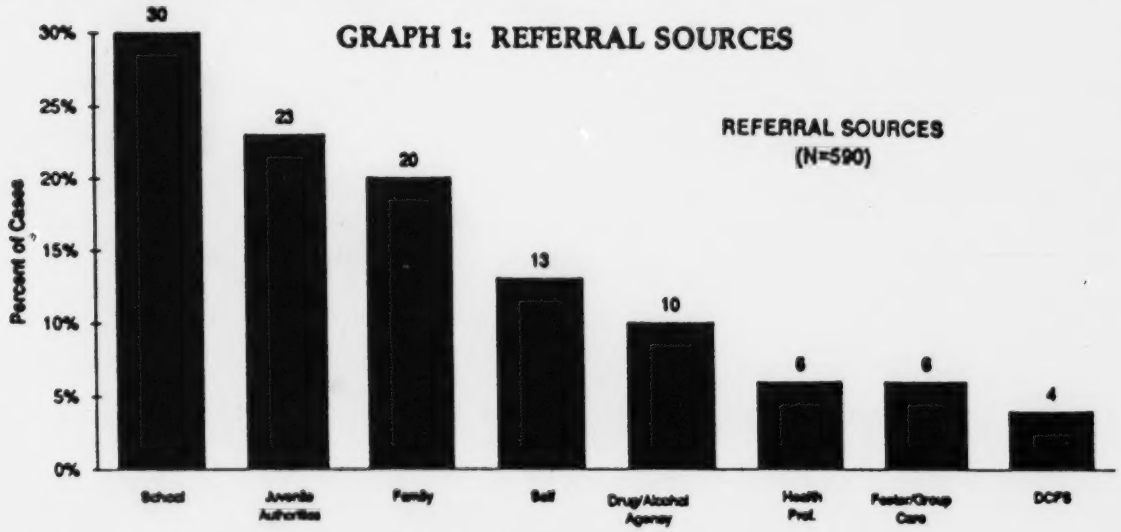
For a detailed list of activities, see Appendix D.

## Division of Alcohol and Substance Abuse

Examining relationships between schools and treatment agencies was a key part of the Adolescent Project's work. Because of limitations in time, staff, and funding, it was decided to do a small case study of only a few schools.

Another part of the Adolescent Project is the recently completed descriptive study of adolescents assessed for substance abuse, "The Client Descriptive Study." That study examined records of 590 such clients from around the state. A significant number (30%) stated "school" as a referral source (Andris, et al., 1992). This case study describes that referral process in four schools.

**GRAPH 1: REFERRAL SOURCES**




NOTE: An adolescent may be referred into treatment by more than one source. Consequently the percents add up to more than 100.
Source: Andris, et al., 1992, p. iii.

## Purpose of the Study

The purpose of the School Case Study is to describe the referral processes of several high school intervention programs, and their relationships with local alcohol/drug assessment centers, as reflected in various staffing models.

## Staffing Models

In discussions with DASA regional administrators, treatment agency directors, OSPI staff, Educational Service District (ESD) staff and school personnel, three different staffing models were identified as most commonly used. An alternative school was included in the study because of the special population such schools often serve.

Staffing models selected for the study are:

MODEL 1. A Chemical Dependency Counselor (CDC) is hired by the school district as the Substance Abuse Intervention Specialist (SAIS). Assessments are done on campus. The SAIS is an employee of the school district and does on-campus assessments and referrals to treatment. In the case study of this model, there is no assessment or treatment agency in the community.

MODEL 2. A staff member with other duties who is not a chemical dependency counselor is designated as the SAIS, and assessments are done off campus. Through an agreement with the school district, an agency is contracted to do assessments off campus. The person designated as an SAIS is often a counselor, as in this case study.

MODEL 3. An agency CDC is contracted to be the intervention specialist and work with the school Student Assistance Specialist (SAS). Assessments are done on campus. The CDC is on campus one day per week and on call other times. The SAIS assists the SAS with the prevention/intervention class.

MODEL 4. An agency CDC is contracted to be the SAIS at an alternative school, and assessments are done on campus. The CDC runs the intervention program and the Recovery Assistance Program (RAP) group. In addition to referrals, assessments are done as part of the entrance requirement for those students with a prior history of a drug assessment or treatment.

**TABLE 1: Four Staffing Models by Task, Hiring Agency, and Location of Assessment**

| TASK | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| General Counseling | School | School | School | School |
| Prevention/ Intervention | School | School | School/Agency (on campus) | Agency (on campus) |
| Assessment | School (on campus) | Agency (off campus) | Agency (on campus) | Agency (on campus) |
| Recovery Support | School | School | School | Agency (on campus) |

Note: School refers to an employee hired by the school district. Agency refers to an employee who is hired by an assessment/treatment agency.

## Descriptive Questions - Areas of Inquiry

Questions concerning the process of an adolescent in school obtaining an alcohol/drug assessment and treatment, and then returning to school, were asked in each of the following five areas:

(1) General information regarding communication between the school and the local alcohol/drug assessment agency.

(2) The referral process within the school of a student to the SAS or SAIS.

(3) The assessment process of a student once identified as "at risk" and in need of an assessment.

(4) The school and treatment agency's communication.

(5) The re-entry of students to the school program and recovery support programs.

## STUDY METHODS

### Case Study

As a case study this report is descriptive in nature. A hypothesis is not tested. It is not intended to be comprehensive, neither is it representative of situations in other schools. Each case is looked at individually. Each school is unique in its population, community and staffing model.

### School Selection Criteria

Using the program staffing model as the main criterion, along with time and budget constriants, four schools were selected. Factors considered in selecting schools for the study included that they have an ongoing Omnibus funded program and that a variety of schools be represented.

Fourteen educational service Districts or Consortia had received Omnibus funds for the 1989-91 biennium. In selecting two counties where the four schools would be chosen, two additional criteria were used:

- that the Client Descriptive Study showed a high number and proportion of school referrals, and

- that a variety of prevention/intervention models existed in the high schools of the two counties.

Factors considered to include a variety of schools that best exemplify the four staffing models were:

- The school size, small (<500), medium (500-1000), and large (>1000).
  In the study two schools are small, one medium and one large.

- The school location, rural or urban and Eastern or Western Washington.
  Two schools are in rural areas, two in urban areas. One school is in Eastern Washington and three are in Western Washington.

- An alternative school.
  One of the smaller schools is an alternative school.

The focus of the selection criteria was on various staffing models of the Substance Abuse Intervention Specialists and the processes of referrals to local assessment or treatment centers within each of the models.

OSPI, ESD alcohol/drug coordinators, and assessment center personnel suggested the schools in the study. Each school represents a specific staffing model. In addition, an alternative school is included because of the special population such schools often serve.

## Case Study Participants

Assessment center personnel, ESD alcohol/drug coordinators and members of the Advisory Committee to the Adolescent Study suggested key people to interview. All persons interviewed were involved in the prevention/intervention process or offer support through their administration. The titles and general duties of the participants interviewed are:

**Principal or Vice-principal:** administration, hiring, evaluation and support of staff, scheduling of courses.

**Counselors:** academic and career counseling for students, crisis intervention.

**Student Assistance Specialist:** a school staff person, usually one with counseling experience, hired specifically to act as counselor and resource person to students with problems other than academic, for example: eating disorders, grief, divorce, alcohol/drugs, etc. This person's tasks include those outlined by the SAP.

**Core Team Member:** any member of the school staff who consistently participates in the group discussion and referrals generated by evaluating the checklist of behaviors for changes that may indicate a student is having problems. Members have usually had some training in the signs and symptomatology of alcohol and drug abuse.

**Chemical Dependency Counselor:** A Chemical Dependency Counselor (CDC) means a person who meets certain requirements to practice in the State of Washington [see Washington Administrative Code (WAC) 275-19-145]. These requirements include specific schooling, registration with the state, and two thousand hours as a counselor trainee.

**Substance Abuse Intervention Specialist:** a person hired specifically for, or whose duties include, intervention with a student when there is cause to believe the student is having problems with alcohol or drugs. This person may be hired directly by the school district or may be a person or agency contracted to provide SAIS services.

## Data Collection and Analysis

Case study staff conducted a personal, one-on-one interview with three to six people in each school including:

(1) The principal or vice-principal,

(2) The Substance Abuse Intervention Specialist, and

(3) A school counselor.

A "core team" teacher was interviewed in three schools. In one school, in a rural area, the counselor taught one class and was a core team member also. The school nurse was interviewed at one school and, at another, an aide was interviewed (see Appendix C).

The schools in this study are in the third year of Omnibus funded programs. To maintain confidentiality it was decided that neither schools nor participants would be identified.

Sixty-five percent of the questions were close-ended or partially close-ended. Open-ended questions were asked with regards to the effectiveness of various aspects of the program. Responses within each school are grouped by program stage (referral, assessment, treatment, and re-entry) and delineated in the respective chapters. In most cases where a respondent answered "don't know," he or she referred the interviewer to the person who did have the information. Answers common to all are discussed in the chapter on findings.

Terminology: In this study twelve women and seven men were interviewed. For ease of reading and consistency, female pronouns will be used as a convention.

Chemical Dependency Counselor (CDC) qualifications are addressed in the Washington Administrative Code (WAC) 275-19-140(3) and WAC 275-19-145. Registration is required when a CDC practices for a fee and that requirement is addressed in the Revised Code of Washington (RCW) 18.19. A person who meets these requirements is referred to as a Qualified Chemical Dependency Counselor.

There are three certification boards in the State that are recognized by DASA. Individuals must meet stricter standards to be Certified Chemical Dependency Counselors than the WAC requires for Qualified Chemical Dependency Counselors.

The three schools in this report that contracted for CDC services contracted for Certified Chemical Dependency Counselors (CCDC). The CDC hired by the school district in Case One is a Qualified Chemical Dependency Counselor (QCDC) working towards her certification.

To minimize confusion and have some consistency throughout the report the term Chemical Dependency Counselor (CDC) will be used for both Qualified and Certified counselors. The term does not include trainees.

It may be argued that schools working with CCDCs benefit from the added experience a CCDC may bring to the program. It is not within the scope of this report to make that determination.

# CHAPTER 2: CASE ONE - SCHOOL DISTRICT HIRED CDC AS SAIS

The selected case is a school located in a town with a population of less than 2,500. It is a rural community, transitioning to a suburban bedroom community. There is one public institution, aside from the usual public services, that employs around 150 people. There are small working farms, and some residents commute out of the area to work. A metropolitan area with a population of over 475,000 is thirty miles away.

The high school's population is between 300 and 400, with a middle and elementary school nearby. The high school has a full-time principal and no vice-principal. The principal handles all disciplinary issues at this school. This affects the communication with the SAIS, as will be discussed in more detail later. The mobility rate (transfers within the district or near-by area) is approximately 17% per year and the withdrawal rate (drop-outs) about 6% per year for the high school. The turn-over rate in a school affects the student/teacher relationships that can be established as well as the flow of information about school programs.

## Staffing Model

The SAIS is employed by the school district and is a CDC and a certified teacher. Work hours are divided among three schools, but approximately 75% of the SAIS time is spent at the high school where the need is greatest. Referrals are generally made to the SAIS through the core team, which meets every other week. Sometimes referrals are made directly by the counselor, administrator or student himself or herself. Assessments are done on campus by the SAIS.

Three interviews were conducted at this school, with the principal, counselor, and SAIS. The SAIS is hired full time for that position. The counselor teaches a class and has contact with most of the students in their sophomore or junior year. The counselor is also a part of the core team. The school staff of less than 20 makes communication quite easy.

## School and Local Treatment Program Inter-Relationships

In this rural area, the closest treatment center is thirty miles away. The counselor finds out about alcohol/drug treatment programs from other school staff, agency personnel, promotional material, and professional associations as well as hearing from students about programs. Networking is the major way the SAIS keeps informed about programs. The principal learns about programs from the SAIS and refers to the SAIS

for information about specific treatment centers most often used by students. The counselor is aware of some treatment centers used by students and has contact with centers regarding school assignments to aid students in their school work while they are in inpatient treatment. The SAIS visits treatment centers and works with the treatment agency in "staffing" a student. "Staffing" refers to a meeting of agency staff and other concerned adults to assess the needs and set a plan for the client while he or she is in treatment.

The respondents each stated that it is the SAIS whom a treatment agency person would usually contact. Though there are no local treatment agencies, the SAIS has worked with non-local agency staff on training and educational seminars, community education and community advisory boards. The SAIS stated that "continued daily contact" was important in coordinating efforts with treatment agencies. The counselor was aware of community education and the Community Youth Activity Program grant. All three respondents interviewed rated the relationship between the Student Assistance Program (SAP) coordinated by the SAIS at this school and treatment agencies as excellent or very good.

Advantages of this case are:

(1) That the assessment person was on staff and was there for emergencies;

(2) That the district got more of the SAIS' time and energy for the money spent compared to the contracted arrangement of prior years where a CDC was on campus one day every other week;

(3) That the SAIS was able to develop a personal relationship and credibility with the staff, students, families, AA groups, and police; and

(4) That the staff had immediate access to information on prevention programs.

Disadvantages expressed are:

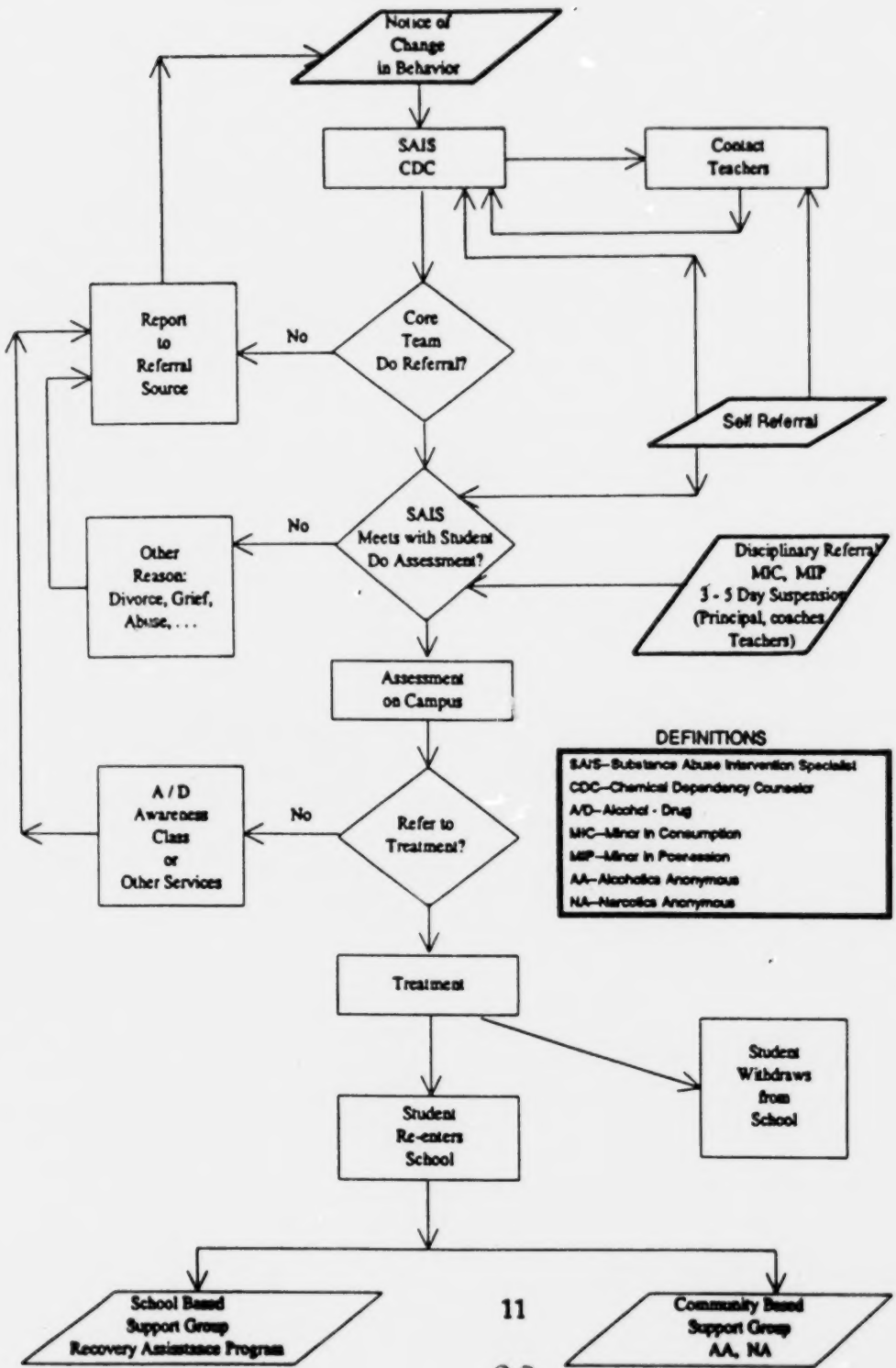
(1) That it was a lot more work than just doing assessments; and

(2) That no one else on the staff had the same training or background as the SAIS so that professional peer consultation was not available.

**Referral Process**

The core team is the main source of referrals to the SAIS in this school (see Figure 2). When a change in behavior is noticed in a student, a checklist of concerns is distributed to all the student's contact teachers. These are returned to the SAIS in a confidential manner (see Appendix A: Checklist One). Then the student is discussed at the next core

# Figure 2
## MODEL ONE: DISTRICT HIRED SAIS / CDC



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team meeting. If it is deemed appropriate, the SAIS will call the student in for a meeting. The SAIS deals with many issues, including children of divorces and eating issues. A call to SAIS does not automatically imply an alcohol/drug concern. Disciplinary referrals are made by the principal. It was stated by all those interviewed that there is active support for the work of the SAIS by administrative staff, the district administration, and the counselor. Most teachers were supportive.

The administrator felt that there was a high percentage of self-referrals and credited this to the prevention and intervention programs of the past several years. He felt strongly that six to seven years ago there were few if any self-referrals. To maintain credibility and confidentiality, she is not told of, nor does she inquire about, self-referrals unless there is concern over harm to self or others, or in cases where child abuse or neglect may be involved. Disciplinary referrals are made by the principal. There appears to be a clear understanding of tasks and responsibilities, and there is mutual respect and support for each other's duties.

All interviewees felt the school had a clearly articulated policy regarding the use of substances in the school environment, and the consequences of not adhering to the school policy were also clearly stated. The school has supported a Natural Helpers [Robert, Fitzmahan & Assoc. (RF&A), 1989] program (peer counselors) for several years, and core team training. A prevention curriculum is available, and some of the material is incorporated into other classes such as biology, chemistry and health, as there is not the population to support a separate intervention class. (According to the SAIS, in schools with larger populations, classes are sometimes offered that specifically focus on intervening in the behavior of youth at risk due to their misuse of or experimentation with drugs.) The PTA has offered some parent education, and information is distributed in the district newsletter.

Assessments

All assessments are done on campus, using a standard assessment tool, widely used in the region. Because of the confidentiality of assessment information, only the SAIS was aware of the percent of students assessed who had A/D problems. Actual statistics on referrals were not kept, aside from the number assessed and the number who actually went to treatment. But the SAIS stated the opinion that 80% of the people she saw were "affected others" (those students who have friends or relatives with serious substance abuse problems). Approximately 20% were assessed as having an A/D problem and 50% as needing information and education only. All respondents rated the internal referral process of getting students assessed, to be very good or excellent. There are no financial considerations in choosing an assessment center, as assessments are done as part of the work of the SAIS.

The respondents stated that the referrals for assessment are successful in part due to the availability of the SAIS, the SAIS ownership of the program, the personal relationships

within the school community, and the support of the counselor and administrator. Though there is not the population for an ongoing prevention/intervention class, aspects of the curriculum are incorporated in other classes. The SAIS has a background in health and psychology, and assists in teaching appropriate sections in health, literature and other classes. There is much student contact through these efforts, and this is seen as very effective by the staff.

Prior to having a full time SAIS on campus who is qualified to do assessments, the school contracted for an agency person to come once every two weeks. This was judged as much less effective by all those interviewed as the contracted person was on campus only 10% of the time, participating in an aftercare class only once every other week.

## Treatment

The SAIS is the one who makes arrangements for treatment. As there are no local treatment agencies nearly all referrals are to inpatient treatment. (Transportation was considered the primary barrier to outpatient treatment as it is more than thirty minutes away.) Wait times for inpatient treatment were seldom a problem except when free (DASA) beds were needed. Other barriers to treatment usually related to getting a parent to agree to residential treatment and working out the insurance/finances.

More individual counseling was usually given to students waiting for treatment and to those students living in a non-treatment supported environment. Once a release is signed by the parents, school data is given to treatment centers. Some treatment agencies are cautious about sharing treatment progress with an SAIS they do not know.

A student could technically be suspended for non-compliance with treatment recommendations, but it has not happened to date. There has been no need to prioritize students for the SAIS services because services have been available as needed for students. There is a teen pregnancy program, where a DSHS staff person comes to the school to talk with and counsel pregnant teens. There are also sexual abuse and eating disorder groups. The SAIS coordinates these groups. Families of students in treatment are encouraged to meet with the SAIS and work with the program at the treatment center if possible.

The SAIS is the main link to the treatment agency, and was the person most aware of factors that have been effective in getting students to treatment. Those factors include parent support, student empowerment in recognizing that the problem is getting bigger and that he or she can change it, and that there is a knowledgeable and experienced person to meet and work with families on staff. Low functioning families (parents in denial and refusing treatment), courts' lack of understanding of the disease and treatment, and surface pain management were all stated to be barriers to treatment. The SAIS is the main contact with the treatment agency, yet all interviewed felt that the

relationship between the school staff and treatment staff was very good or excellent. As to interaction with agencies where students are being treated, it was stated that it was "critical that agencies work to keep school informed of clients' progress and to provide aftercare." Some treatment agencies have satellite centers where weekly aftercare groups are held. The SAIS stated this was a need in this community.

## RE-ENTRY

The majority of students referred from this school return after inpatient treatment. The SAIS is notified by the treatment agency when a student is about to finish treatment. There is an informal re-entry procedure, as the students are not always withdrawn from school but put on a tutorial leave. There is a staffing done for awareness of students' needs and a program partner (student "buddy") is assigned to the re-entering student. The student meets with the principal and starts school half-time for a couple of days before returning full time. Few students continue with a community-based aftercare treatment program, as distance to the nearest one is too great. All participate in the school recovery support program and may do so for the rest of the school year or longer as needed. A major part of the Recovery Assistance Program (RAP), [Seattle, King County Department of Public Health (S-KCDPH), 1989] curriculum is used in this class. Most students also connect with a local twelve-step program.

Not all students in the school aftercare program have been in treatment. In a larger school, students looking for support for their own self-prescribed treatment (ie., staying clean on their own without treatment), may attend an intervention class, but this school does not have the population to support such a class. The SAIS at this school expects the student who has not been to treatment to be "clean," i.e. drug free, for at least 21 days, the minimum length of an inpatient treatment program, as a prerequisite for participation in the aftercare class. There is minimal concern around the issue of confidentiality on the part of students in the aftercare class as in this size school almost everyone knows who is in what classes. Though there is confidentiality among those within the class and with teachers, there seems to be little concern among the students. Those not willing to work with the program are not permitted to continue in the class.

Observed improvements in students who have been in treatment and aftercare were hard to pin down for those interviewed in this school. Respondents noted that changes vary greatly from student to student. Generally speaking, there is improvement in grades and attendance as "parents are on the kid's case." Another said, "Kids, when they first come off [drugs], are often worse academically for a while as it is hard to focus and concentrate." All those interviewed stated that those who choose to stay clean make significant strides in improved attendance and school work, reduction in behavior problems and A/D use, and have increased coping skills. Some improvement was noted in peer relationships and increased school activities. Family relationships are often noted to be the same, but students' coping skills are better than before treatment. According

to the SAIS alcohol/drug treatment often opened the way to "next step recovery," especially in self-identified sexual abuse cases. Often in such cases, counseling on those problems began after treatment. It is felt that in the recovery support program, "...youth are identifying healthy boundaries and relationship choices and that many of the kids will take a life path change."

Community services most often needed by students who have been in treatment include: support groups (AA, NA, COA), sexual abuse counseling and family counseling, anger management, transportation, job training, and ongoing A/D treatment. The SAIS also felt that safe housing (alternative to returning to a student's home), an alternative school and planned parenthood education were needed. Support groups were stated as the number one priority, followed by an alternative school, and employment programs. (Less than half of those students who graduate from this school go on to higher education or some training, including military). Support groups such as AA are the only aftercare available in this community. Other needed services are a half-hour or more away, and transportation is needed.

The re-entry program is rated excellent or very good by those interviewed. Factors contributing to this include: the school population and community being much more knowledgeable about the disease, staff training, staff and kids very supportive, sensitive and encouraging to returning students, the daily for-credit recovery support class, and that a personal advocacy relationship is established with a caring adult. Driving students to weekly off-campus meetings has been less successful in supporting students in aftercare.

## Analysis and Conclusions

- Availability of the SAIS and a caring supportive staff and administration are the common factors stated in the success of this program. The SAIS also noted technical assistance from the Educational Service District (ESD) and the Center for the Study and Teaching of At-Risk Students program (C-STARS) at the University of Washington.

- A/D education is reported to be the major factor in the increased number of self-referrals, according to one staff member with nearly thirty years in the educational field. "There would be more drop-outs and sick kids without this program," another said. It was felt that peer referrals have greatly increased, too, with the understanding and awareness of the disease concept, and the move away from moral and legal issues to focus on health problems.

- Continued budgetary support for intervention programs is seen as very necessary. As one respondent said, "The school would not have been able to move in the direction it has. It shows an absolute commitment to the curriculum of

Prevention/Intervention and [serving] at-risk kids and has linked family, school and community together. The money helped break down denial a little bit in a community of high need." The school has established a core team and there are student and community advisors. It was felt that it takes a couple of years for the SAIS to get to know the community and to build up the program and trust.

- The SAIS appears to be the key to community mobilization around alcohol and drug issues, aside from disciplinary issues. In addition to facilitating the intervention program and aftercare class, the SAIS also works on community education, youth groups such as Natural Helpers (RF&A, 1989) and cross age mentoring of high schoolers with elementary & middle school children, parent education programs, coordination of core teams and district policy, coordination of Omnibus and Federal funding, and works on accessing other grants and faculty development. There is much contact with regional agencies in seeking the appropriate services for a student. The SAIS is known to most of the students, being the coordinator of A/D information for the health and family life class, and assisting in other classes.

This staffing model seems to work well for this school and community. There seems to be little, if any, follow-up on agency based treatment for aftercare by either the treatment agency or school. Referrals are made to private counselors if a community has no treatment facility, according to one agency counselor. Financing of such private treatment may be a problem for many. The SAIS is a resource for many issues other than alcohol and drugs. If the community wanted a comprehensive aftercare program, it seems that the school would be the most likely place. This SAIS is qualified to teach such a class, but would need to schedule time for case management, having individual case files progress notes for each student in the class, which are some of the components of an accredited aftercare treatment program.

<u>Summary</u>

The SAIS is employed full time by the school district and works mostly with the high school population of less than 400. The staff works well with the core team in the use of a checklist to help evaluate student behavior. There is no assessment or treatment facility in this rural community, so assessments are done on campus by the SAIS who is a CDC. Most referrals are to inpatient treatment centers because distances to outpatient centers diminish their effectiveness when students do not go. The ongoing aftercare program offers support to those returning from treatment and to those willing to stay clean on their own. A school based program for assessments and aftercare seems to work best for this rural area, though a need was stated for an alternative school and community-based aftercare.

# CHAPTER 3: CASE TWO - STAFF WHO IS NOT A CDC DESIGNATED AS SAIS

A rural community of 5,000 with a predominantly agricultural base is the site of this school. This town is within ten miles of a city ten times its size, and is somewhat of a bedroom community to the city. Though there are a number of light manufacturing plants in the larger community, the base industry is agriculture.

The school's population is around 800, drawing from a school district whose boundaries contain about 20,000 people. The principal and one vice-principal work full time at this school. The withdrawal rate (drop-outs) is about 3% per year and the mobility rate (transfers within the district or near-by areas) is between 10% and 15%. The district does have an alternative high school and there are a number of transfers between the schools.

## Staffing Model

In this school the two counselors are the designated intervention specialists. They carry on the usual tasks of counseling, scheduling, career counseling, and crisis intervention, in addition to working with a prevention/intervention group and a recovery support group. The counselors have chosen to split the focus, so that one facilitates the prevention/intervention class and the other the recovery support group. The counselors are not CDCs. All assessments are done by CDCs at agencies off campus.

Five interviews were conducted at this school. Respondents were the principal, each counselor, a core team teacher, and a faculty aide active in the referral process with the core team. In addition to the school staff, an alcohol/drug counselor from the agency most often used for assessments was interviewed. A meeting was also held with the alcohol/drug coordinator of the ESD.

## School and Local Assessment Agency Inter-Relationships

Networking is the most commonly mentioned method of learning about A/D treatment agencies. Counselors (SAIS) receive information and promotional material about treatment programs from agency personnel as well as from professional associations. The teachers interviewed learn about new treatment programs from the ESD Counselors and administrators make visits to assessment/treatment agencies and other staff interviewed expressed interest in doing so.

As assessments were not done on campus, those interviewed (except for the SAISs') were knowledgeable about agencies to which referrals for assessments are made, but less knowledgeable about actual treatment agencies. The SAISs had this information and felt they had good contacts with most agencies used.

The school and assessment agencies have coordinated their effort by working together on community education such as alcohol/drug education week, shared training either by the agency or the ESD, and by an assessment person participating in the core team meetings. Teachers would like more education by agency staff and on-site visits to treatment centers. Special training around issues of family dysfunction and addiction is also a stated need.

One question was asked if any assessment/treatment center that the school used had closed and its effect on the school referral program. One treatment agency in the area did close, but it was felt that the closing did not affect the program.

As the SAISs at this school are also the school counselors, they are seen as the resource for many other needs a student might have, whether academic or emotional. They also have primary responsibility for keeping records of any alcohol or drug referrals.

For six years one assessment agency has been training school staff about the issues of alcohol and drugs through student assistance programs. This has brought about a lot of networking, confidence in each other's programs and mutual respect. With the number of at risk kids, a need for an additional counselor was stated, as was the desire to make referrals for parents.

Overall, the relationship between the local assessment centers and the school was seen as excellent or very good. This staffing model, with counselors designated as SAIS, and referrals for off-campus assessments, was seen as working well for this school and community.

Advantages stated for off-campus assessments are:

(1) More privacy for student and family, protects confidentiality,

(2) Separates academics from family dynamics and health care issues,

(3) Validates referral as important,

(4) Earlier involvement of the family and student in the need to take the responsibility in getting the assessment,

(5) Family sees it as more important, and

(6) Referral/treatment agency has more information, seen as more professional.

Disadvantages to this model are:

(1) Transportation - assessment offices are four-to-seven miles away,

(2) Parent support is often not available, so many students just do not get their assessments done, and

(3) Assessment staff does not get to be known by students; staff is seen only later when co-facilitating recovery support group.

Referral Process

This school has a strong, well established core team from which most referrals to the SAIS are made (see Figure 3). One counselor, though, felt that there were a significant number of self referrals. For core team referrals to the SAIS, the referral process is usually as follows:

(1) Some change in student behavior is noticed,

(2) The change is brought to the attention of the counselor (SAIS), usually in a one on one meeting,

(3) A checklist is distributed to the contact teachers of the student (except for self-referrals to the SAIS in which case confidentiality is maintained),

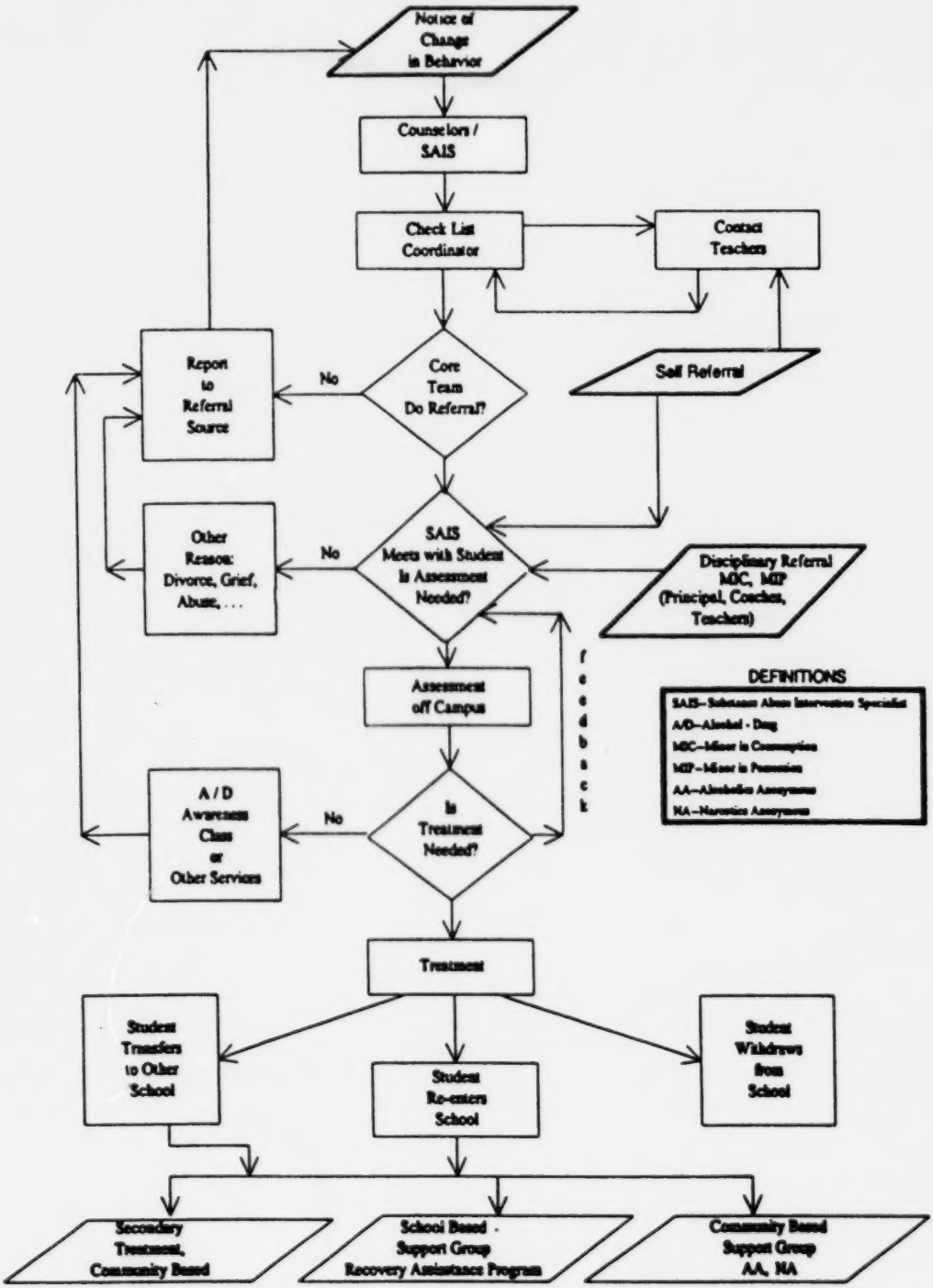
(4) The checklists are collected and brought to the core team meeting,

(5) The student is discussed and a referral to a counselor, SAIS, is made if deemed appropriate, and

(6) The student is called in by a counselor.

A designated core team member distributes and collects the check list (see Appendix A: Checklist - Model Two). Parents and coaches are referral sources as well. Those interviewed rated the referral process very good or excellent. There was some concern about the core team meeting only every other week, reducing timely follow through.

# Figure 3
## MODEL TWO: COUNSELORS AS SAIS – OFF CAMPUS ASSESSMENTS



Confidentiality of self referrals is maintained unless a release has been obtained. Core team members are notified at the next meeting that appropriate action has been taken on prior cases considered. All interviewed felt that the school had a clearly articulated policy regarding the use of alcohol and drugs in the school environment. The school district uses a specific curriculum for its prevention program. The high school has the Natural Helpers program and prevention education for the core team members and other staff.

Student support groups were mentioned by everyone when asked about prevention programs in the school. There are or have been groups for sharing general concerns of students, sexual abuse victims, alcohol/drug problems, children of divorce, and academically skilled students who are under a lot of stress. Support groups came up when talking with the ESD coordinator as well. The feeling was expressed that support groups help kids deal with issues that put them at risk, and risk seemed to encompass anything that undermined or interfered with the students' academic progress.

Though there are many ongoing programs for students, there is no ongoing prevention program for parents though sessions have been offered. Prevention/Intervention programs for parents have usually been held as the result of some crisis. Such emergencies include a student coming to a game or dance drunk, or being in a serious or fatal traffic accident. (In this eastern Washington community, many of the roads are narrow and the winters often harsh, so that serious student accidents often occur each year.) Parental attendance at prevention/intervention classes is very high at first after such an incident, but then falls off after a couple of meetings.

## Assessments

After reviewing the checklist and considering use and family history, a student is usually referred for an assessment by one of the counselors. If there is a violation of the school policy, the vice-principal usually makes the referral with the knowledge of the counselor. All interviewed felt the process of getting students to an assessment was excellent or very good.

Factors stated that have been most helpful in getting students to assessments were:

- Family support and encouragement,
- Treating the problem as a health not moral issue, and encouraging the family that an assessment is a healthy choice,
- A clear school policy that is widely understood and enforced,
- A consistent method and process for referrals in place, and

- Parent or school staff bringing the student to assessment agency.

Less successful methods stated for getting students to assessments included:

- Confidential referrals - no parent support,
- Casual suggestion - not taken seriously by student,
- Threat or coercion - creates a defensive position, and
- Teachers working with student outside of core team - student will sometimes confide in a teacher and ask for confidentiality; student is looking for safety and is often scared.

The school district pays for assessments with the Omnibus drug funds. There was some concern expressed over the cost of assessments, noting that some fees doubled when Omnibus funds became available. Most places have a sliding fee, and some treatment centers offer free assessments. Once an assessment is done, a copy of the treatment recommendation is sent to the school counselor.

## Treatment

General information about treatment can be obtained from the school, but since assessments are done off-campus, the assessment centers have more specific treatment information. It is felt that outpatient treatment is accessible within a few days and inpatient as soon as a bed is found and finances have been worked out. DASA eligible students and those with mental illness may have delays in obtaining a bed. Once a release is signed by student and parent, there was no problem stated in exchanging information between school staff and treatment staff.

Universally, among all those interviewed, the main barriers to treatment were reported to be:

(1) Denial of an alcohol/drug problem,

(2) Lack of parental support, and

(3) Finances.

For those students living in a non-treatment supportive environment, there is usually more individual counseling given. The student is informed of his or her rights and a confidential referral may be made without the parent/guardian's consent. Such a student is also brought into school groups.

Attendance at an outpatient treatment program is monitored if it is a condition of staying in school. The treatment center staff usually notifies the counselor of a student's attendance in an outpatient treatment program. The counselor also hears about attendance at the outpatient treatment program from students in the recovery support groups at school. It is also in support groups or from a treatment agency that a counselor finds out that a student is thinking of quitting treatment.

If a counselor hears that a student may be thinking of quitting treatment, then the student will usually receive more individual counseling at school, the counselor may meet with the family, and the counselor may discuss the matter with the treatment agency. There may be school suspension if treatment attendance is a requirement for staying in school. One counselor stated that disciplinary-referred treatment does not take into consideration the student's readiness or lack of readiness for treatment. The first step of awareness of the problem is raised, though.

Since assessments are done off campus, mostly at a referral agency, there is little personal contact with treatment agencies by school staff. The school counselors maintain phone and letter contact with treatment agencies out of the area.

The Division of Alcohol and Substance Abuse has a priority list for those receiving services when treatment slots are full. Priorities include, pregnant or parenting women, IV drug users, cases involving Child Protective Services, Division of Juvenile Rehabilitation cases, and students in group homes. When asked if this school prioritized students for any needed services, the answer was "no." Though some services were more readily available than others, it was felt that students received the services they needed. One counselor expressed the need for longer (60 days) treatment programs and gender-specific treatment centers. The school offers support groups for many special needs. There are alcohol/drug family components through most treatment agencies.

## Re-entry

Among the school staff interviewed, it was felt that nearly 100% of students who leave for inpatient treatment come back to the same school. The referring agency thought the percentage was closer to 75%, with other students going to the alternative school or dropping out. Most school districts do not consider a student a drop-out if the student transfers within the district. The school counselor is usually contacted by the treatment agency discharge coordinator or parent when a student has completed treatment. A counselor meets with the student to arrange class schedule and appropriate group participation.

Aftercare is arranged for returning students by the treatment agency, though it was felt by most school staff that follow-through was weak. The most widely used aftercare

program is in the next town and counselors stated that they coordinate recovery support programs with them. There are some AA groups in the local community. In the recovery support program at school, nearly 100% have been in treatment. (At the time of the survey in the fall, students had been in treatment the previous school year.) The school counselor (SAIS) facilitates the recovery support group at school with part-time assistance from a CDC from the assessment agency. Though there is confidentiality among staff and within the particular groups, it was stated that the students seem to be very open about group participation. Though there is no particular parent component to the aftercare program, parents are supportive by driving students to AA meetings.

Though all those interviewed noted at least some improvement in most students who have participated in treatment, it was noted that some very good students have gone to treatment and not all students who are using have behavior problems. Most did not know if there had been an improvement in family relationships, but felt that students had better coping skills. School personnel felt that the first several weeks back were critical. One stated, "Peer pressure will get them, [student] needs to give up old using group who wants kid back as he [or she] was before, but [its] tough to break into new group." Counselors and administration felt that if students got through the first several weeks they would do all right and that there would be some continual improvement through aftercare. One counselor estimated 10% to 15% return to treatment. Others who relapse drop out of school and may return later to the alternative school.

There were three services needed by students who have been in treatment that were listed by all those interviewed. These services are:

(1) Support groups such as AA and COA,

(2) Ongoing alcohol/drug treatment, and

(3) Family counseling.

The counselors and agency person also felt there was a need for safe housing, an alternative to returning to the student's home, sexual abuse counseling, and anger management programs.

The re-entry program was rated excellent or very good by almost everyone interviewed at this school. The willingness of the school to fund a program for re-entry, the various support groups, the administrators, the counselors, and the teachers making it feel okay to be here, are stated as reasons for a successful re-entry program. Areas of concern included the need for better staff training as to what aftercare is and the need for community-based support in addition to the school program. A meeting with the family prior to the student coming back from treatment was stated as desirable by a counselor, in order to prepare a program for the student. Now the school is usually given just one or two days' notice by the treatment center that the student will be released.

## Analysis and Conclusions

A strong belief in the Student Assistance Program, shown by the manner of the administration and the caring staff, contribute to the success of the prevention/ intervention program at this school. According to one respondent, students have said that they are "tired of A/D lectures." They know at the school though, that, "... a problem is not ignored, there are resources to deal with it, and that there is a system for kids when they get back." Staff stated the need for more parental involvement.

The availability of Omnibus funds is credited as the reason most students received assessments, though a concern was expressed that assessment costs went up when the State funds became available. One staff person wished funds would be available for family assessments. The school has been able to hire support staff for the counselors so that they would be free to facilitate the support groups and do the additional work of an intervention specialist. Aftercare support and continual training by the local assessment agency has aided the staff with their programs. There seems to be a strong sense among staff and ESD that off-campus assessments work well for this school and community.

## Summary

The two full-time school counselors are the designated SAISs at this high school of nearly 800 students. A checklist filled out by each teacher with whom a student has contact is used by the core team and counselors in evaluating student behavior. To separate educational issues from other issues (emotional, family, substance abuse) assessments are done off-campus. This staffing model is used throughout this ESD. Referrals to treatment are done through the assessment center with the SAIS at the school notified. The school uses a specific curriculum for its prevention program. The many different groups at this school, it is felt, support the students in dealing with a variety of issues. Though there is a well established aftercare program at the school, there is little involvement in community-based aftercare as it is several miles away and there is no public transportation system.

# CHAPTER 4: CASE THREE - SCHOOL CONTRACTED ON CAMPUS CDC

A large metropolitan city is the site of this school. There are significant manufacturing and shipping industries and major shopping and distribution centers.

There are a number of high schools in the school district with an average population of around 1300 as is the school in this study. Alternative schools are not factored into this population average. The school has a principal and two vice-principals. The withdrawal rate (drop-out) is 10% to 12% and the transfer rate (those who transfer within the district) is about 14 percent. There is a large core group of students that is geographically stable.

## Staffing Model

At this school there is one counselor specifically hired as the Student Assistance Program Specialist (SAPS) doing much the same work as the substance abuse intervention specialist (SAIS) at the other schools in this study. (The SAPS will be referred to as the SAIS for consistency in the report.) The SAIS's duties include coordinating the prevention/intervention program and the aftercare class, working with the core team, and working with the district-contracted chemical dependency counselor (CDC). There has been a core team at this school for eight years. Assessments are done on campus by the CDC except when disciplinary action has been taken. In such cases, a student is suspended for a month, but may return in five days if an assessment is obtained.

Six interviews were conducted at this school. One vice-principal, who had more history with the school than other administrators, was interviewed along with the SAIS, a counselor who had been the SAIS the prior year, a core team teacher, the school nurse, and the contracted agency chemical dependency counselor (see Appendix C).

## School and Local Treatment Program Inter-Relationships

This school district has an A/D coordinator from whom most of those interviewed received information about local A/D programs. Agency personnel, promotional material and professional associations are sources of information also. The CDC at the school receives information through her agency and has found the state treatment list hotline useful. To the CDC, the students returning from treatment are a good source to learn about the quality of various treatment programs.

Most of those interviewed made on-site visits to treatment centers and were aware of the centers most often used by students. Two staff members were aware only of the agency with which the CDC is affiliated. As a general practice the agency contracted CDC does not make referrals to her own agency. In this case, students tend to choose outpatient treatment centers that are closer than the CDC's agency. The school counselor and CDC had detailed knowledge of the treatment centers used and insurance information regarding payment. All stated that the SAIS would be the primary contact for an agency person when calling the school.

The school and treatment agencies are aided in coordinating efforts by having an agency assessment person in the school, if only part-time, and by agency personnel attending school district meetings. Additional ways suggested to coordinate efforts include: interagency meetings to exchange philosophies and share programs, visits to treatment agencies with presentations geared to teachers, joint training of teachers and agency staff about adolescents and A/D use, and a directory of all resources to help kids.

When a nearby outpatient treatment center closed that served students from this school, they were sent to another. Other centers, however, were further away and a concern for safety was expressed about adolescents traveling across the city. There is also less follow-through when a center is too far away. As this school is in a large urban area, the staff has access to many services a student might need. The school district offers many programs and services as well.

The school counselor and nurse work well with local treatment agencies by having developed personal contacts and relationships over the years. They would like time for exchange of program information and to clarify guidelines and philosophies between the school and treatment centers. The CDC contacts most treatment centers monthly and visits occasionally, but would like to do so more often. The relationship between the local assessment agency and the school prevention/intervention program was rated very good or good by most.

All staff interviewed felt that this staffing model, with a full time SAIS and contracted CDC for on-campus assessments, worked well for this school and community.

Advantages of this model stated by those interviewed are:

- The SAIS is full time and a certified school counselor;
- Assessments are done on campus;
- No transportation problems to interfere with student completing assessment;
- The SAIS and CDC are available for self-referrals;

- The agency CDC contact with school staff and students, serves as a link among schools, treatment centers and community programs; and

- The school has more information on a student than an assessment agency off-campus.

A disadvantage of this model noted by the persons interviewed is:

- The CDC is at school for assessments only; time cut from last year. CDC is not available for core team meetings and aftercare as in the prior two years.

The above statement reflects the disadvantage aired by all those interviewed at this school and may be a result of the budget cut and not this particular staffing model.

It was stated by one counselor that the SAIS, counselor, and CDC are working with some of the toughest problems and most dysfunctional families in the system. A CDC needs to be at the school at least half-time to work with the SAIS and to co-facilitate groups. Working together, they feel that they complement each other and see the residual effects of the of the prior two years work even with the current program cuts.

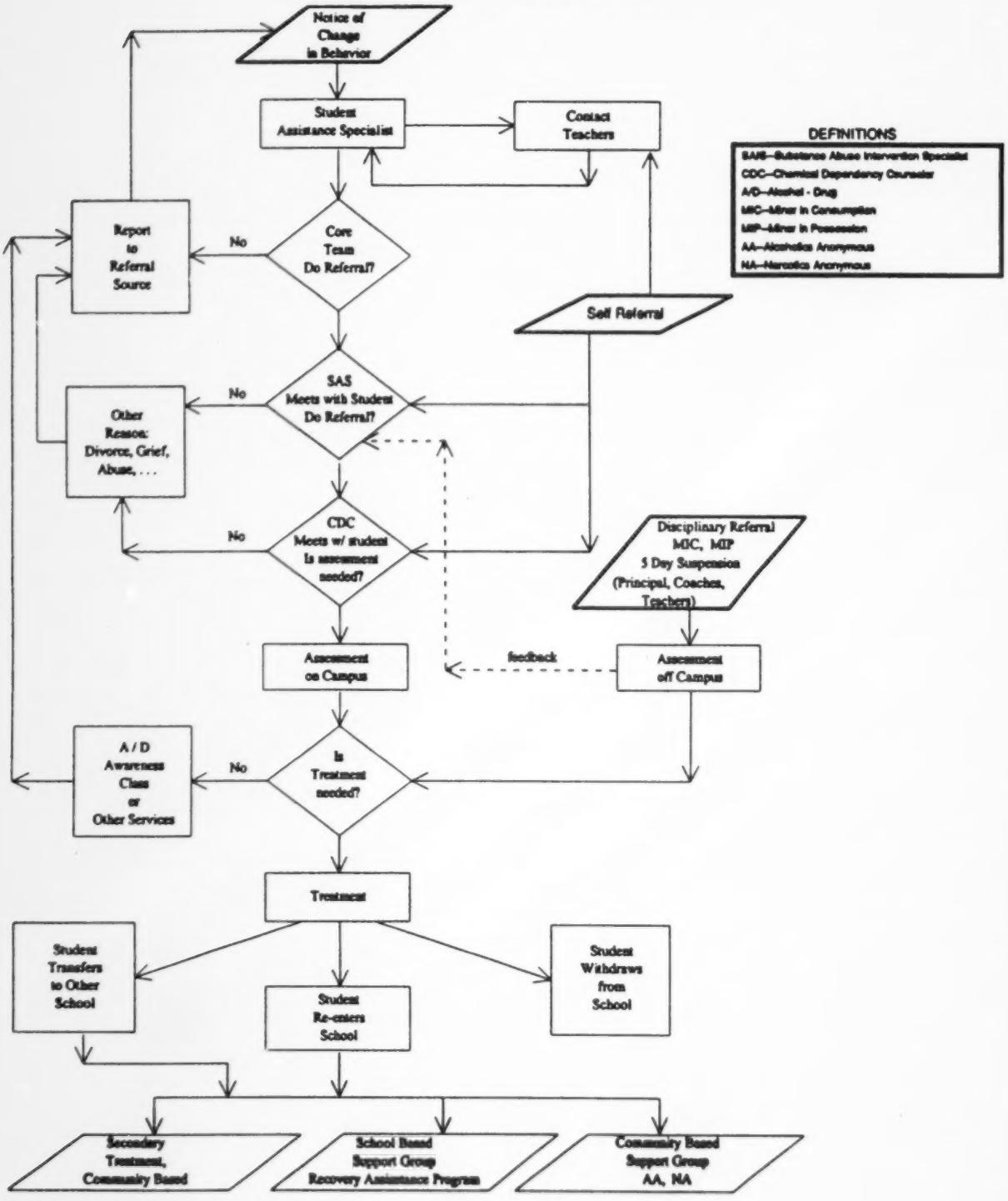
## Referrals

A Core Team has been active at this school for eight years. There is strong faculty support for the Student Assistance Program (SAP). As one said, "The whole faculty is involved." The SAIS communicates with the rest of the staff via the core team, staff meetings, personal contact and memos. Teachers, other than core team members, were reported to be the primary referral. This is not surprising considering there are over seventy staff. The nurse and CDC thought that there were significant self-referrals too. It is not unusual that these professionals would note this, because self-referrals would be out of the usual sequence, and most self-referred students would go to either of these people (see Figure 4).

Active support for the work of the SAIS came from all areas within the school. One used the term "strong advocacy," in referring to the sense of support among the staff. The CDC mentioned that the security staff support for the program is shown by their notifying administrators and counselors of activities in conflict with school policy.

All staff interviewed were aware of the checklist used by the core team in evaluating a student's need for a referral to the SAIS (see Appendix A: Checklist - Model Three). Criteria from that are used in making the initial referral to the SAIS. The most common ones mentioned are: slipping grades or attendance, erratic behavior, and student's peer group, activity or conversation. Sometimes there is a meeting between teacher and student before a referral is made, but generally there is none.

# Figure 4
## MODEL THREE: FULL-TIME STUDENT ASSISTANT WITH CONTRACTED SAIS, CDC



The core team meets every other week. The longest period of time between the first awareness of a problem a student may be having and being called in by the SAIS would be about three weeks. Any emergencies are seen right away. Once action has been taken, a feedback form is sent to the referring party.

A number of referrals, equivalent to nearly 14% of the student body, were made during the school year 1990-91. There was a full-time SAIS and a half-time CDC on staff then. Drug and alcohol information is taught in the health and psychology classes. There are additional classroom presentations and it is felt that 90% of the students are given some prevention/intervention information at some point through each year. There have been prevention/intervention training for core team members, other staff and student leaders.

There is a clearly articulated school policy regarding the use of alcohol/drug substances in the school environment. There seemed to be a clear understanding of the consequences of violating this policy as well. There have been town meetings for alcohol and drug education, at area high schools, every few years, but generally these have been crisis related. The internal referral process of getting the student to an assessment person in the school was rated fair to excellent.

## Assessments

Once a student has been referred to the CDC, a determination is made as to whether an assessment is needed. Of those referred to the CDC, respondents felt that 90% to 100% had an alcohol or drug abuse problem. Assessments are done privately in a room separate from other activities so that confidentiality is maintained.

Discipline-generated assessments are done off campus while the student is suspended. The parents may choose from a list of assessment agencies they are given. The parent or guardian is responsible for the cost of assessments from a disciplinary referral. Most agencies have sliding scale regarding fees and some agencies in the area offer free assessments.

Strategies found successful in motivating a student to get an assessment include:

- Having a clear school policy regarding the use of alcohol/drugs,
- SAIS helping a student identify problems and look at issues (family, emotional conditions),
- Assessing to rule out A/D use as a contributing factor in concerns, and
- Establishing trust between students and counselors.

Less successful strategies mentioned in motivating a student to get an assessment are:

- Telling a student she has to tell parents;
- Direct referrals, not going through counselor; and
- Being confrontational, as it creates a defensive posture.

According to the staff in this case study, the factors making the intervention part of this program effective include:

- A full time SAIS on staff,
- Administrative and faculty support and involvement,
- Staff training,
- Faculty working together, core team in existence for seven years, and
- Caring and trust among staff and counselors with students.

Treatment

Once an assessment has been done and the need for treatment is determined, the CDC and SAIS meet with the student and parents, and treatment options are discussed. Sometimes right after an assessment, with the student still in the office, the CDC will call treatment agencies to check for space availability. The assessment outcome, along with the student's own stability and support systems are some of the criteria stated by the CDC in considering treatment options.

The counselor and CDC felt about 80% of those needing treatment actually went. Some students just don't go. For some students and parents denial sets in if there is a wait time and others use the "geographic fix" by moving or withdrawing from school.

Treatment could begin within a day or two, according to everyone interviewed, except for students needing free beds. Bed availability, finances/insurance and willingness of family to cooperate were the key factors as to when a student could start treatment.

The main barriers to treatment stated in this case were:

- Lack of parental support,
- Denial of an A/D problem, and
- Finances.

Other barriers to treatment stated by those interviewed included: transportation, fear of parents' knowing, the parents' work schedule, and parents' own addictions. Students living in a non- treatment supportive environment are given more counseling both by the counselors and the CDC. A confidential referral to outpatient treatment is sometimes made. As one respondent said, "Sometimes the kid is the most healthy person in the family." The counselor works to find someone in the family to support the student.

There is sometimes a delay in getting a parent and student release. Once this is obtained, there is exchange of school information with the treatment center. Generally there are no problems caused by the different hours between the school and treatment agencies once, as one stated, lunch schedules are learned.

The counselor, SAIS, and administrator knew that there was some monitoring of students in outpatient treatment. The SAIS contacts the treatment agency or a report is sent by treatment staff to the school. If school staff hear that a student is thinking of leaving treatment before completion, the school counselor may discuss the matter with the treatment agency or, in case of a disciplinary referral, the administration may threaten suspension.

Though the law mandates that Child Protective Service cases receive top priority, there has been no need to prioritize students for services at this school. Most services a student needs are available in the community and many are available within the school environment.

The key factors stated as important in getting a student into treatment are:

- Self referrals,
- School policy,
- Core team and counselors' concern,
- Campus assessment, and
- Comprehensive parent conference and immediate commitment to treatment.

Less effective strategies stated in getting a student to treatment are:

- Group education, general lectures about A/D,
- Lack of follow up to assessment recommendations,
- Suggestions for treatment made by someone a student does not respect, and

- Sending a student to treatment when there is no family commitment, family still in denial.

Some staff expressed the need for agencies to be more visible in the school, to get to know the building and the staff. It is felt that it takes teachers three years to get to be known and integrated within the staff. The feeling was that agency people need to come in and give more seminars and training.

The SAIS has offered group sessions to families of students in treatment, but no one came. The school has an open door policy for parents and they are encouraged to meet with the counselor.

**Re-entry**

The school staff felt that most students (about 90%) returned to this school after treatment. The CDC thought a bit less. She felt that the "geographic fix" is used, when "the kid is often shipped off to the other parent." She felt that this was not uncommon, and often done before treatment, because the custodial parent, "... did not want to deal with it."

While in inpatient treatment, most students are on academic leave and do continue with any school work assigned. Upon re-entry, they meet with the SAIS to set up a schedule and get into a support group. The school is usually contacted by the agency or parent when the student is ready to leave treatment. If a student leaves treatment early, the parent usually notifies the school. A counselor reported that sometimes the student will just show up at school.

Most staff interviewed were not aware of students going to a community outpatient treatment program after returning from inpatient treatment. The CDC and counselor were aware that this is a desired sequence. The counselor thought that only 70% of the students returning from inpatient treatment participated in an outpatient program, and of those who did, many did not complete the program. One respondent stated, "kids make their bonding to groups while in treatment and don't want to re-begin relationships once they come back home." She felt that there was "very poor community aftercare" though some parents may be involved in aftercare programs through the treatment agencies. There is no program through the school, but counselors are open to meeting with parents at any time.

Students returning from treatment enter the living skills class, for which they can receive up to two health credits. The Recovery Assistance Program (RAP) curriculum is used. It is facilitated by the SAIS with assistance one day a week by the CDC. The CDC assisted every day last year. The reduced hours are felt to decrease the effectiveness of the program and decrease student relationships with the CDC.

Of those in the RAP class, 70% to 85% have had prior treatment. The others have made a commitment to abstinence and to working with the group. Generally, students stay in the class through the rest of the year and may continue the class as an elective for additional semesters.

One question in the interview asked, "Would you say, generally speaking, that you have seen improvement in most students who have participated in treatment?" (A similar question was asked later in the study about students who have participated in aftercare.) Respondents were then asked about specific areas (attendance, behavior, and grades) and asked to rank improvements in these areas.

Respondents resisted answering these questions and generalizing about students. They said they often could not tell which aspects of students' lives are improved. Not all students, they insisted, had school or behavior problems before treatment.

If students have not relapsed, respondents said, they generally do well. But many respondents noted, also, that there is a four to six-month transition time after treatment that is difficult and important. Some comments they made about students' lives and progress or problems in that time were:

(1) "Awareness higher, they can never go back to using as before. They now have a conscience they were lacking."

(2) "They have learned tools for coping with life."

(3) "The realization that even though they stopped using, there are still problems in their lives, but they are not killing themselves with alcohol and drugs anymore."

(4) "If a student is not self-directed and self-motivated, he or she will not respond to any treatment regardless of how much money you spend."

(5) "There are changing peer relationships and some isolation. There is a lowering of self esteem than from right after treatment and a potential suicide risk. Student needs consistency."

(6) "If someone has a contact person, a shadow person, when first out of treatment, then there is about 85% success. A kid in abstinence but not in recovery will often relapse."

(7) "If [student] stays in recovery, then she needs to learn how to adjust to life without drugs. It's really tough in the four-to six-months time period [after treatment]."

Though respondents resisted answering the interview's questions about post-treatment

improvements, they shared concerns about critical factors for students in the months just after treatment. It was stated that there is generally at least a reduction in alcohol/drug use, and in behavior problems. Sometimes school work was better, and sometimes there was an increase in school activities. Respondents often stated they see improvements in students' self-esteem and coping skills after treatment.

Community service needs

In responding to the question, "What type of community services do your students who have been in treatment most often need?," the top three services stated are:

(1) Ongoing alcohol/drug treatment,

(2) Support group such as AA, COA, NA, and

(3) Anger management/family counseling.

Employment programs, sexual abuse counseling and safe housing as an alternative to the student returning home were also stated as needs. One area with which the CDC was familiar was the need for better linkage among the schools, treatment centers and employers. People are reluctant to hire those with a history of drug abuse. It is also difficult to get insurance with a history of drug or alcohol treatment. She feels that more education needs to be done in this area.

Re-entry program rating

On average, the re-entry program at this school was rated very good. Factors contributing to the success of the program were reported to include:

- Cooperative and flexible staff to meet the needs of the students,
- Informal mentoring - students feel safe to have a relationship with a concerned adult, and
- Recovery Assistance Program (RAP) - safe place to talk and to practice skills.

Factors contributing to a less successful re-entry program were said to be:

- School not being told of prior treatment history, as with summer programs,
- Not getting the student into a support group, and

- Teachers not being aware of recovery issues with the student.

One staff person stated that if the peer group the student ran with is still at the school, then recovery is more difficult, as the student needs to make new friends among pressure to return to the old group. It was stated that a patchwork response, instead of an ongoing program, undermines treatment.

Program evaluation

After focusing on each phase, staffing model, referral, assessment, treatment and re-entry, the staff was asked to comment on the program as a whole - what has made the program work at this school and what has been less effective. Comments on the Omnibus-funded program were also solicited. Effective program strategies include:

- Strong administrative and staff support for program,
- Acknowledgement of problem,
- People educated in A/D issues, and
- Consistency of a program, especially of the core team, year to year.

Respondents stated that turnover of staff and administration makes it difficult to have the consistent build up of trust and confidence between students and program. Information about RAP, as it floats through the student body, is undermined by inconsistencies in the program.

Continual funding of programs is seen as a key to prevention. A continual program from first grade on, is seen as needed. One counselor stated that to identify students at risk and get them into prevention programs, "[high schools] need A/D counselors at feeder schools." It was felt that a minimum of four years is needed for any program as time is needed for information about the program to be distributed and trust to be built. One staff member expressed the personal feeling that teachers are burned out at the end of the day, but feels that if there were a monetary incentive more teachers would choose working with high risk kids over coaching. Another stated "soft money" (money not fixed in the budget, year to year) is seen as a waste of time and taxpayers money. Schools need to know by January about programs and money for the coming school year.

## Analysis and Conclusions

This school is very comfortable with an agency person on campus. The CDC is seen as a major asset in the Living Skills classes using the RAP curriculum. The commitment

of the faculty is demonstrated by the volunteer core team that has been operating for eight years.

Denial on the part of parents is seen as the major barrier to students' accessing treatment programs. One respondent stated that there used to be town meetings annually at the high schools around drug issues. There is a lot more information out now and different places to access the information, from county and private health facilities to libraries. Still, as one said, there are parents who just do not care. Comments from those interviewed at this school regarding the lack of parent concern over substance abuse issues include:

(1) Many of the parents were the children of the late sixties and may still be using themselves,

(2) Some parents do not see alcohol or drug use as a problem, and

(3) Many parents are still in their own denial.

It was felt that there is less success with assessments done for disciplinary reasons. There is no mandate for parents to follow the assessment recommendations nor for a second assessment to be done if one is found to be inconclusive. That students can bias an assessment outcome is not unknown according to the CDC.

Even though funding cuts affected the staffing of the program at this school, the strong administrative support within the school is felt by those involved.

## Summary

This large urban school contracts for assessments to be done on campus by a CDC from a local substance abuse assessment/treatment agency. A core team has been active at the school for eight years and receives much support from the school administrators.

The Student Assistance Program Specialist (SAPS) works with the CDC and the core team members in assessing students' needs. A checklist of behaviors, distributed to a student's contact teachers, is used as the initial evaluation tool. The CDC is available to do assessments on a weekly basis and is on call for emergencies. The CDC works with the student, parent(s), and SAIS in arranging treatment if necessary. A number of treatment options are available locally. The Recovery Assistance Program (RAP) curriculum is used in the aftercare classes. Some students transfer to other schools within the district including the alternative schools. There is a need for anger management and family counseling and more CDC time on campus. It was stated that it is difficult to plan programs from year to year when there are major budget changes.

# CHAPTER 5: CASE FOUR - ALTERNATIVE URBAN SCHOOL, WITH CONTRACTED CDC

This school is located in the same large metropolitan city as the school in case three. There is more than one alternative school in the district, so students have some choice of where to attend. However, a student must apply to get into this school, there is a waiting list, and the final placement decision is made by the school staff.

The school population averages around 300. Because this is an alternative school, there is a high turnover rate. Students may come for just half a semester, though there are no limits on the length of stay. In a recent year over 65% of the students were there one semester or less. In the course of a year the school might actually serve nearly twice the average number of students in attendance at any one time.

The principal has a number of other alternative sites to administer in addition to this school. There is no vice-principal housed at this school, and no administrator on site every day, all day. There is a full-time counselor and a teaching staff of around fifteen.

## Staffing Model

The Chemical Dependency Counselor (CDC) is on staff three and one-half days a week. Contracted by the district as the Substance Abuse Intervention Specialist (SAIS), the CDC works closely with the counselor in assessing and placing new students in an appropriate group. Students entering with a history of an A/D assessment or treatment are assessed again as part of the entrance requirement.

Each teacher acts as a mentor or advocate for an assigned group of students. There is not a formal Student Assistance Program, but the advocates fulfill a lot of the same functions as core team members in schools that use the core team approach. When a student enrolls, a faculty person is assigned to act as an advocate for the student. The advocate and his or her students meet as a group at least weekly, and for an additional full week once a month.

Interviews were conducted with the principal, counselor, SAIS, and a teacher. The teacher has been at the school for four years. The SAIS was a certified teacher and the counselor is a CDC. The counselor and SAIS stated that they felt this cross training adds to the understanding of and respect for each person's responsibilities.

## School and Local Treatment Program Inter-Relationships

The school-contracted CDC at the school is the main source of information about treatment programs in the area. The school district A/D coordinator, professional associations, and agency promotional material are additional information sources about treatment programs.

Most of those interviewed had made on site visits to treatment programs. The principal does so in monitoring school programs at other sites, some at treatment centers. The counselor has prior experience as a CDC at an intensive outpatient treatment facility and has visited other treatment programs as part of that work. Except for the teacher, all had direct contact with treatment agencies. They often knew someone on the staff, but usually dealt with the intake person, counselor, or discharge staff as the situation demanded. It was reported by respondents that there was a lot of changes in staff assignments at treatment agencies.

Advantages stated for this staffing model were:

- SAIS on campus who is a CDC, allows easy access to assessments,
- All staff involved through advocacy program adds support to SAIS, and
- Low turn over among staff and working with the same SAIS enable trust to build among staff and students.

Disadvantages stated for this staffing model were:

- Contract changes year to year, better to have a school district person hired in an ongoing program, and
- SAIS at school only 75% to 80% of the time, reduced from 100% the prior year, so continuity of programs was disrupted.

The SAIS or the student's advocate is the main person contacted at the school by a treatment center. The treatment agencies and the school coordinate efforts by having shared training and workshops and by joint case staffing on students. In the latter, the SAIS usually goes to the treatment center to meet with staff in planning a treatment program for the student.

It was felt by all those interviewed that joint agency meetings and additional agency training would be beneficial. Respondents said they wished there were an information network or umbrella organization for all people who work with children and A/D problems.

Though some treatment agencies have closed or moved, staff have found other treatment centers to serve students. The school staff use school or community agencies to obtain other services a student might need as well, including special education, mental health counseling, teen pregnancy classes, and transitional housing. There is a teen parenting program at the school.

The relationship between the school and the assessment agency is considered very good. Both the counselor and the SAIS have many contacts in the field. More frequent visits to agencies and having agency personnel come to schools are both seen as beneficial by those interviewed. Some sort of accountability for quality care in A/D treatment and more training for those doing assessments were seen as two ways to improve working relationships with treatment agencies.

Though the SAIS is on campus 75% of the time and works with the students in many different groups, it was felt that a full time person is needed. A district hired person, it is thought, would help with the continuity of the program. It was stated that it is very difficult to run a program with different funding and grants every year or so.

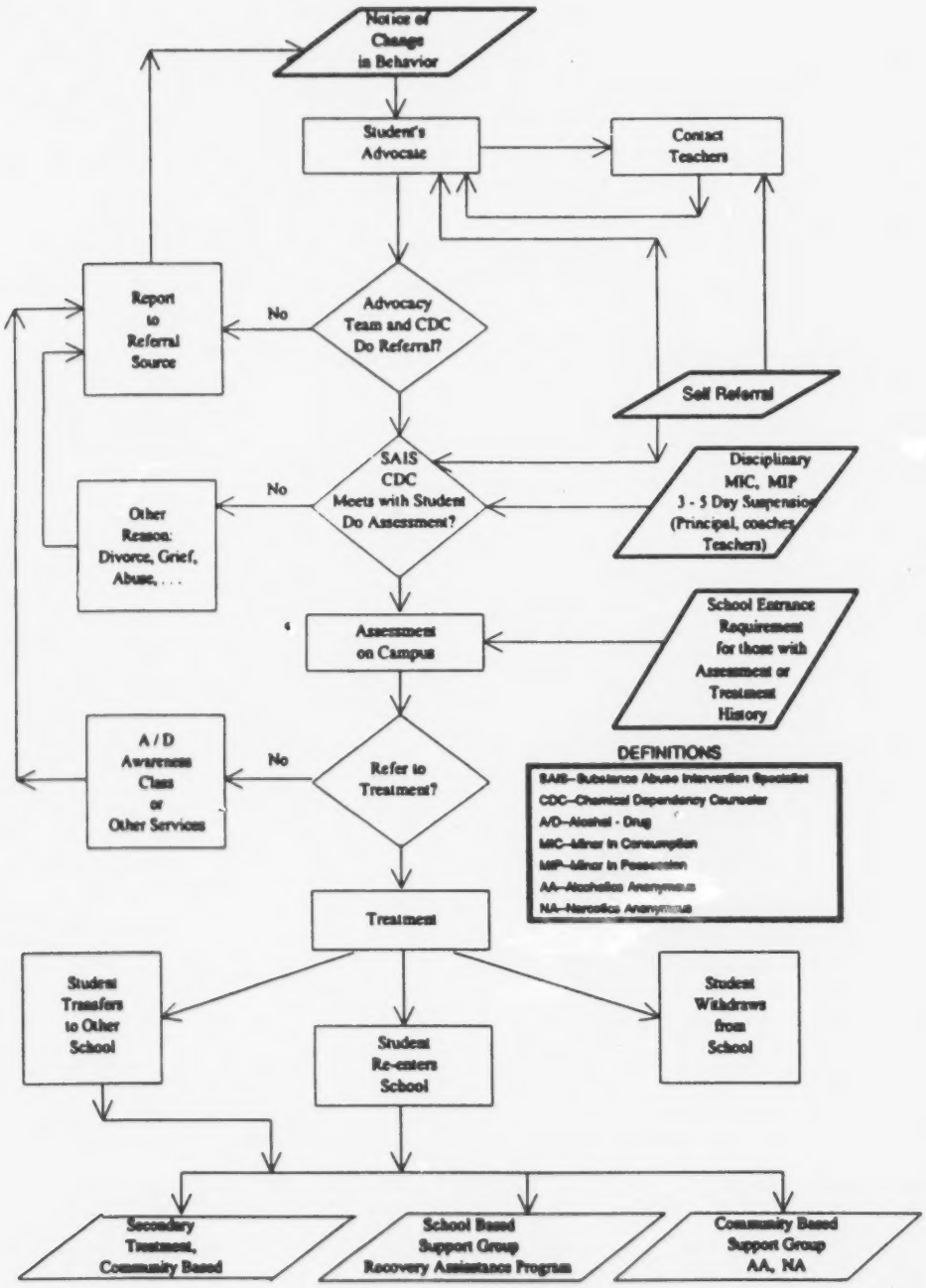
Referrals Process and Assessments

Being an alternative school, assessments are done as an entry requirement for any student with a past history of drug assessment or treatment. Recent figures show that students with such prior history constitute about 8% to 10% of the students entering this school throughout the year. The counselor refers the student to the SAIS as part of the placement procedure. The teaching staff is the other main source of referrals to the SAIS. Since this is a fairly small school, referrals are usually made in person to the SAIS when a change in behavior is noticed. A parent may express concern or the student may reveal a use issue to any staff member (see Figure 5).

The counselor or student advocate may meet with the student once to discuss a potential A/D problem or a referral may be made directly to the SAIS. A checklist is distributed to the contact teachers, and then the results are discussed with the advocacy team (see Appendix A: Checklist - Model Four). An assessment is usually done within a few days if thought necessary. Of those referred to the SAIS about 85% were given an assessment, and of those assessed 67% were thought to be beyond the experimental stage in their alcohol or drug use.

As they are in the same school district, this school has the same policy regarding the use of substances in the school environment as case three. A minor in possession (MIP) or consumption (MIC) of a controlled substance is automatically suspended for the rest of the semester. However, he or she may return in three to five days if they have an assessment and agree to follow the recommendations. These assessments are usually done on campus by the SAIS.

# Figure 5
## MODEL FOUR: ALTERNATIVE SCHOOL WITH CONTRACTED SAIS/CDC


Notice of Change in Behavior
Student's Advocate
Contact Teachers
Report to Referral Source
No
Advocacy Team and CDC Do Referral?
Self Referral
SAIS CDC Meets with Student Do Assessment?
No
Other Reason: Divorce, Grief, Abuse, . . .
Disciplinary MIC, MIP 3 - 5 Day Suspension (Principal, coaches, Teachers)
Assessment on Campus
School Entrance Requirement for those with Assessment or Treatment History
A / D Awareness Class or Other Services
No
Refer to Treatment?
DEFINITIONS
SAIS--Substance Abuse Intervention Specialist
CDC--Chemical Dependency Counselor
A/D--Alcohol - Drug
MIC--Minor in Consumption
MIP--Minor in Possession
AA--Alcoholics Anonymous
NA--Narcotics Anonymous
Treatment
Student Transfers to Other School
Student Re-enters School
Student Withdraws from School
Secondary Treatment, Community Based
School Based Support Group Recovery Assistance Program
Community Based Support Group AA, NA

Prevention information is taught in the health classes. There has been some staff training in the past with very little staff turn over, so most of the staff are familiar with the prevention/intervention curriculum. An annual training to update staff is usually scheduled. Additional training in adolescent behavior is thought to be beneficial. It is sometimes hard to distinguish normal adolescent behavior from alcohol/drug affected behavior, it was stated.

A number of factors contribute to the cooperation of students in getting an assessment. That most students are re-entering the school system and must apply for admission is one major factor. Assessment requirements are clearly stated as part of the entrance and disciplinary policies of the school. The student advocate is key in getting a student to have an assessment. Having a SAIS on site for quick feedback is seen as an asset. As this is a small school, the staff know the assessment person; trust and confidence have been established among the staff. To have the student recognize the assessment process as an information tool is an important strategy as well.

In questioning staff about less effective methods used in intervention programs, one person responded, "Confrontation." This creates barriers and resistance that must then be overcome, it was explained. In disciplinary cases, parents are necessarily called in and may not be very supportive. They may focus on the disciplinary action and not the behavior underneath, according to one person interviewed.

Treatment

With assessments done at the school, treatment decisions are made at school with the student and parent(s). A list of treatment options is discussed, and includes consideration of financial obligations, degree of severity of the problem, and ability of the student to stay at home. Inpatient treatment is recommended if detox is needed or if the SAIS assesses that the student is unable to succeed in an outpatient treatment program. There is usually no wait for an outpatient treatment slot. There is sometimes a wait of up to three weeks for a state-funded inpatient bed. Students waiting for treatment are often given more individual counseling, enter an intervention group and may enter a lesser level of treatment, such as regular outpatient instead of intensive outpatient.

Lack of parental support, denial that an A/D problem exists, and finances are seen as the main barriers to treatment. A concern was expressed about safety issues around young women going to outpatient treatment or AA support groups in the evening. One staff member has provided personal transportation for students. The school district provides public transportation passes for those in need, but the concern expressed was for the students' safety.

It was agreed by all surveyed that students living in a non-treatment supportive environment get more individual counseling. An effort is made to bring the parents in for counseling. The students are informed about their legal options for self-referral to outpatient treatment. School data is released to the treatment agency once a release has been signed by the student and parents. There have been no problems with confidentiality regulations in this regard.

More individual counseling is scheduled for the student currently in outpatient treatment who is thinking of leaving. A student may be suspended from school for non-compliance with treatment recommendations. According to the administrator this happens sometimes.

When asked if this school prioritized students for any needed services, the answer was, "no." Though some services were more readily available than others, it was felt that students received the services they needed. There are many resources available for adolescents in the community, so the school has had few problems in referring students for other services needed, such as mental health.

According to the administrator, counselor and SAIS, most other school staff have little or no contact with treatment agency personnel. Those interviewed stated the relationship between them and treatment staff was excellent or very good.

Main factors listed as helpful in getting a student to treatment were:

- Parental support,
- School district policy and advocate program,
- Student's desire to change and recognition of need for assistance in the change, and
- Adequate finances.

General comments regarding treatment included the following needs: a higher level of communication between treatment centers and the school, an individualized treatment plan for aftercare, more competent clinicians at some agencies, and a residential treatment program in the area.

<u>Re-entry</u>

About 75% of the students who leave for inpatient treatment come back to this school. A re-entry conference is held with the student, the counselor, the student's advocate and the SAIS to agree on a program contract and assign the student to an aftercare group.

The counselor is usually contacted when the student ends treatment. It is estimated by the SAIS that less than 50% of the students returning from inpatient treatment go to outpatient treatment in the community for aftercare in addition to the recovery support program at school.

Students returning from treatment participate in the recovery support program for the rest of the school year. They may continue for as long as they are at the school if they wish. The SAIS facilitates the class and the RAP curriculum is used. About 80% of those in the recovery support program at the school have been in treatment. There is no parent component to the aftercare program at the school. Parents are encouraged to meet with the counselor or SAIS and to participate in the program set up by the treatment agency.

Community services most often needed by students who have been in treatment include:

- Ongoing A/D treatment;
- Support group, such as AA, NA, COA; and
- Anger management and family counseling at affordable rates.

There is also a need expressed by the counselor for transitional housing, sexual abuse counseling and general counseling for parents. Each person interviewed rated the re-entry program as very good. The SAIS stated the need for time to visit students while they are in treatment.

## Analysis and Conclusions

As with other alternative schools, the alternative school in this case study has a high turnover rate. This makes it difficult for most staff to get to know the students well. To counter this, the school has an advocacy program that assigns a student to a staff person when the student enrolls.

All those interviewed thought it was important to have assessments done on campus. Assessments are required for anyone enrolling with a prior history of alcohol/drug treatment or an assessment. The SAIS is also available when an assessment is needed due to a disciplinary action.

The same SAIS helps facilitate the intervention program and the aftercare program, and this helps the SAIS to be known by the students. It was felt that this adds to the number of self-referrals.

Figures were not available as to how many students who leave for inpatient treatment

actually return to this school. There are also no figures available on the number of students participating in community based aftercare in addition to the school based program.

**Summary**

A SAIS, who is a CDC, is contracted to work at this alternative high school of 300 students thirty hours per week. As there is a high turn-over of students, a faculty person is assigned to act as an advocate for the student upon enrollment. A checklist is distributed to contact teachers when a behavior of concern is noticed. The advocacy team meets with the SAIS to discuss the student and decide a plan of action. If an assessment is done the SAIS discusses the results with the student and parent(s). Many services are available in this urban community. Students returning to this school after treatment enter the recovery support program. Greater involvement in a community-based aftercare would compliment the school program it was felt. There is a great need for low-cost anger management classes and family counseling.

# CHAPTER 6: FINDINGS

The preceding chapters describe the prevention/intervention programs operating in four high schools. Though the models varied by the SAIS time, task and contract, as well as other factors, common elements are evident among the schools. Unless otherwise stated these findings are true in all four cases. This chapter looks at these findings in the following areas:

- Key links in school referral procedures,
- Substance Abuse Intervention Specialist links with treatment programs, and
- Students' re-entry to school after treatment, and recovery support programs.

## Key Links In School Referral Procedures

All respondents provided information on two key links in the referral process. These links are:

(1) The communication between the school and the local assessment agency, and,

(2) The referral process within a school to an assessment person.

### School and Local Assessment Agency Communication

- It was reported that administrative support for the student assistance program and the work of the SAIS facilitates the communication with assessment and treatment agencies.
- In all schools studied, the SAISs and CDCs are the key links with alcohol/drug assessment/treatment agencies. Few, if any, other staff have any contact with other assessment or treatment personnel.
- Networking was the way most school counselors and SAIS's found out about alcohol/drug treatment programs. This was brought about through:

  (1) Working with treatment personnel and concerned citizens on Alcohol/Drug Awareness Week; and

(2) Contacts made through classes offered by the ESD's.

Referral Process Within a School to an Assessment Person

- A supportive administration was the main factor reported by all but administrators as necessary for a successful referral program in a school. This support is shown by:

  (1) Budget support and encouragement of core team activities, and

  (2) Enforcement and follow through of school policy regarding the use of alcohol/drugs.

- When a change in behavior has been noticed in a student, a referral to the SAIS is generally made with no student-teacher meeting.

- Cooperation of contact teachers and their awareness of the signs and symptoms of A/D abuse is vital in supporting the work of the core team.

- A clear and consistent school policy regarding the use of alcohol or drugs is seen by all interviewed as a major factor in the referral process.

- There has been a significant increase in the number of self-referrals in the past several years. According to the respondents this is due in part to:

  (1) The increased awareness of alcohol/drug abuse brought about by school and community education programs; and

  (2) The availability of an A/D specialist the student can go to confidentially.

- The two most common reasons expressed by those interviewed supporting the need for school-based programs are:

  (1) That students are most accessible while at school, and

  (2) That for some the school may be the most stable part of the student's life.

In these four schools it was reported that people from multiple disciplines, school administrators, school counselors, SAIS, teachers, and CDCs, work together for the benefit of the students. The counselors, SAIS, and CDC are, it was stated, often working with the toughest problems and the most dysfunctional families in the system.

This study found that in the four cases examined in this study most SAIS work with a myriad of issues, so that a student need not expect concern about drug/alcohol use when called in by the SAIS. If there was an A/D concern, assessments were most often done right away or an appointment for an assessment was made at this initial meeting.

Education of teachers and other school staff about the signs and symptoms of chemical dependency is the key in teachers' making referrals to the core team members. This education and its importance, set by the administration, are the foundations for the referral process within the schools. Most of the school staff interviewed noted the need for continued education in the areas of addiction and family dynamics. They found the programs offered by local assessment/treatment centers or the Educational Service Districts to be very beneficial.

Since staff and administration support is so important for the referral programs to work in the schools, the participants in the study were asked about support for the work of the intervention specialist. The respondents in this study are involved in strong on-going programs. All stated that there was active support for the work of the SAIS by administrators, counselors and core team teachers. There was less support by some teachers.

In interviews with treatment agency personnel and school staff, reasons given for lack of support by some teachers include beliefs that:

(1) Intervention programs do not belong on campus;

(2) Intervention programs disrupt classes;

(3) The school community has no A/D problem;

(4) Intervention programs force teachers to face their own addictive behaviors; and

(5) The teachers may have used and abused alcohol or drugs as adolescents themselves and see it as a normal part of growing up.

Such attitudes as institutional enabling are discussed in "A Guide for the Treatment of Adolescent Chemical Dependency," [Division of Alcohol and Substance Abuse (DASA), 1989]. This guide states that:

> Any behavior, action or omission which allow[s], promotes or ignores the use of illicit drugs or alcohol by a child or adolescent is considered enabling. This includes attitudes of caretakers, teachers, or other professionals responsible for the learning, recreation and/or treatment of children or adolescents. The modeling behavior of some are seen to be enabling when either casual illicit use of drugs or alcoholism are part of

> the model's lifestyle. Lack of training in substance abuse issues related to teen culture by individuals working with children and/or adolescents may create an enabling atmosphere. The attitude of 'kids will be kids' tends to enable and prolong adolescent use of chemicals (DASA, 1989, p. 10).

Several respondents expressed concern about meeting the multiple problems of young people. One stated her belief that A/D counseling sometimes focuses on abstinence while ignoring major emotional problems an adolescent may have. Others noted that CDC's don't always have the broad and deep training in adolescent psychology that many school counselors have.

A number of respondents expressed concern about the changes in programs from year to year. One stated that all the education about the seriousness of the A/D problem is undermined when programs are not consistent from year to year; that the programs become eroded and ineffective. One counselor felt that a minimum of five years is needed to establish a program, and to build the trust relationship among staff, counselors and intervention specialists.

**Prevention/Intervention Specialist Links with Treatment Programs**

The Assessment Process

- Main factors in having a student get an assessment include:

  (1) A consistent referral method and process in place,

  (2) A clear school policy regarding the use of A/D that is widely understood and enforced,

  (3) An assessment person available on campus, who gets to be known by staff and students, except in Case 2 where assessments are done off-campus,

  (4) Treating use as a health not a moral issue, and looking for root causes of noticed behavior - family, emotional issues, use, and

  (5) Family support and encouragement.

- Financial considerations were not a factor in making referrals at schools where assessments were done on campus by district-hired or contracted SAIS, as SAIS is salaried or contracted per hour and not per assessment done.

- Confidential referrals for an assessment made without the parents' knowledge are seen as less effective by the counselors and SAISs', as there is no support system to encourage follow-through on assessment recommendations.

How Students Get to Treatment After an Assessment

- All those interviewed stated that the main factors in getting a student to treatment include parental support and a clear school policy about A/D use.

- The main barriers to treatment stated by those interviewed are:

  (1) Lack of parental support,

  (2) Denial of an A/D problem (often on parents' part), and

  (3) Lack of adequate insurance or finances.

- Transportation is a barrier to outpatient treatment in two ways:

  (1) In rural areas no public transportation is available and distances are too great for consistent attendance, and

  (2) In urban areas, concern was expressed by the teachers interviewed for the personal safety of young women going to support groups or to outpatient treatment.

- The SAIS or assessment person is the main contact with treatment agencies. There is little other contact between school staff and treatment staff. Needs stated by staff to enhance the cooperation with treatment centers include:

  (1) More A/D education of school staff, and

  (2) Availability of counselor or intervention specialist to participate in staffing a student.

"Staffing" is the procedure where adults of significance to the student, such as the A/D counselor, treatment staff, dietician, school counselor or teacher, parent, etc., come together to discuss and formulate a treatment plan for the student (see sample letter regarding "staffing" in Appendix E). To have the SAPS or assessment person participate in "staffing" a student at a treatment agency is very beneficial. But even in urban areas where facilities may be close by, it often takes half a day according to the SAIS and counselors interviewed. This much time away from school is difficult to arrange. In rural areas, travel to treatment centers often takes most of the day.

Student Re-Entry to School after Treatment, and Recovery Support Programs

- According to those interviewed, seventy to 100% of students who are referred to

and complete inpatient treatment return to the same school.

- Respondents felt that re-entry programs are most successful when the student knows there is a place for him or her upon return, a supportive group of peers, and a caring staff.

- Most respondents noted that the first few months after treatment are most critical in two ways:

  (1) The student needs to make new friends if old ones are still using drugs, and

  (2) The student realizes that life without drugs does not solve other problems in his or her life.

- All those interviewed stated that the community services most needed by students returning from treatment include:

  (1) Support groups such as AA, COA, NA, 12-step programs,

  (2) Ongoing A/D counseling - community aftercare, and

  (3) Family counseling and anger management.

A similar question was asked in another part of the Adolescent Project. Interviews were conducted with assessment and treatment agency administrators and counselors. When these persons were asked what they felt were the community services that clients needed after treatment, they most frequently mentioned the following:

(1) Family counseling,

(2) Safe housing, and

(3) Drug free activities.

Treatment agencies usually include support groups and aftercare in their treatment plans for each client, so additional A/D counseling and support groups were not mentioned by those interviewed in the Adolescent Project. A major need seen in both studies is for family counseling.

Each school in the study had a program for returning students. In most cases a student is put on academic leave while in treatment and not formally withdrawn from school. Re-entry consists of scheduling classes, updating school work and assigning the student to the appropriate support group. The returning student usually meets with the school

counselor and SAIS and may meet with the principal or vice-principal.

Recovery Assistance Programs incorporated in for-credit classes, such as Life Skills or Health and Family Life, provide the ongoing support needed in aftercare. Attendance at community based aftercare programs was seen as important to complement the school program. The community based aftercare program was non-existent in rural areas and minimally used in other areas according to those interviewed in this study.

A clear connection with local outpatient treatment centers to coordinate community-based aftercare was not evident. Treatment plans, especially from inpatient facilities, are to include an aftercare provision. Few school staff members felt that the students returning from inpatient treatment participated in local community-based outpatient treatment as aftercare. Staff referred to local AA meetings as aftercare. There seems to be a need for more education and a clear distinction between a support group such as those found in most schools and AA, and phase two treatment (outpatient treatment provided and monitored by an accredited treatment agency).

In interviews conducted as part of the Adolecent Project, chemical dependency counselors and administrators were asked about phase two treatment and aftercare. Some indicated that there are community-based aftercare and outpatient treatment programs in buildings adjacent to school grounds or located on a bus line coming from the school. These programs, they said, are held right after school at times and locations convenient to the students. Such programs were not evident in this limited study, and there seemed to be a lack of awareness of this phase of treatment by most school staff who were interviewed. Further study may be needed to examine use of community based aftercare programs by adolescents.

Majority Responses to Key Questions

Table 2 shows the majority responses to some key questions in the questionnaire by type of school model studied. Questions focused on the substance abuse intervention specialist's (SAIS) schedule and referral process within the school. Questions were asked about assessments, treatment and re-entry. Listed are the majority responses within each school and these should not be compared to other schools, as each represents a different staffing model and community with different resources. A number of questions with the same response ("yes" or "no") are listed following the table.

Though ongoing A/D treatment was stated as a need for students returning from treatment, most staff interviewed did not distinguish between support groups such as Alcoholics Anonymous (AA) and treatment. Even in rural areas where there is no outpatient facility, agency staff said that they make referrals for private counseling as part of the discharge aftercare plan. Aside from the intervention specialists, most staff were not aware of this. This seemed to be the weakest link in the treatment cycle.

# Table 2
## INTERVIEW QUESTIONS WITH MORE THAN HALF OF RESPONSES IDENTICAL WITHIN A SCHOOL

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| +Relative Size of School | 1.25 | 2.8 | 4 | 1 |
| Number of Interviews | 3 | 6 | 6 | 4 |
| How many hours/ week is the SAIS at this school? | 30 | 40 | 40 | 25-30 |
| How many hours/week is the CDC at this school? | 30 | n/a | 8-10 | 25-30 |
| Do you make on site facility visits to treatment centers (schools)? | no | yes | yes | yes |
| How would you rate the relationship between the school P/I Program and the local assessment/ treatment agencies? | Excellent | Very Good | Good | Very Good |
| Who most often makes a referral within the school to the SAIS? | Core Team Teacher | Core Team Teacher | Other Teacher | Other Teacher |
| After initial awareness of a possible A/D problem, how many times does a student meet with a core team member or counselor before being referred to the SAIS? | none | none | none | one |
| Of the students referred to the SAIS, what % are assessed as having alcohol/drug abuse problems? | 20% ** | 70% | 95% | 67% |
| Overall how would you rate the internal referral process of getting students to the SAIS and/or assessment person? | Very Good | Excellent | Very Good | Very Good |
| Are there financial considerations in choosing an assessment center? | no | split * | yes | no |
| How many assessments were done last year? (% of school population) | 5% | 5% | 7% | 22% |
| Whether assessed at school or a local agency, is wait time for treatment a problem? | no | split* | yes | yes |

NOTE: Majority responses are within each school, and should not be compared to other schools, as each represents a different staffing model, and community with different resources.

Definitions: SAIS - Substance Abuse Intervention Specialist; CDC - Chemical Dependency Counselor.

+School Size: Model 4 is the smallest, Model 3 is the largest; Model 3 is about four times as large as 4.

*Split: Equal number answered "yes" and "no".

**Referrals are made to Substance Abuse Intervention Specialist for many different reasons.

There is no local A/D treatment agency in this community, and there may be more pre-screening at other schools. Percentages are estimates, as no actual figures are kept.

## Table 2 (continued)
### INTERVIEW QUESTIONS WITH MORE THAN HALF OF RESPONSES IDENTICAL WITHIN A SCHOOL

| | Model 1 | Model 2 | Model 3 | Model 4 |
|---|---|---|---|---|
| If a student is assigned to outpatient treatment, does the SAIS or CDC at the school monitor the student's attendance at the treatment program? | no | yes | yes | no |
| How would you rate the relationship among school staff and the A/D treatment staff most often used by your students? | Very Good | Very Good | Good | Excellent |
| Roughly what % of your students who leave for inpatient (IP) treatment come back to this school? | 100% | 95% | 75% | 75% |
| What % of students in the recovery support program have recently been in IP treatment or are currently in outpatient (OP) treatment? | 67% | 98% | 74% | 80% |
| Are families involved in the recovery support program? | yes | split* | yes | no |
| Do you coordinate recovery support programs with local OP treatment agencies? | n/a | yes | no | yes |
| How would you rate the re-entry program at this school? | Very Good | Excellent | Very Good | Very Good |

NOTE: Majority responses are within each school, and should not be compared to other schools, as each represents a different staffing model, and community with different resources.

Definitions: SAIS - Substance Abuse Intervention Specialist
CDC - Chemical Dependency Counselor

+School Size: Model 4 is the smallest, Model 3 is the largest; Model 3 is about 4 times as large as 4.

*Split: Equal number answered "yes" and "no".

**Referrals are made to Substance Abuse Intervention Specialist for many different reasons.

There is no local A/D treatment agency in this community, and there may be more pre-screening at other schools. Percentages are estimates, as no actual figures are kept.

**Majority in all models responded "yes" to the following questions:**

1. Does the school have a clearly articulated school policy regarding the use of substances in the school environment and the consequences (including referral to the SAIS) of not adhering to school policy?
2. * Do students returning from inpatient treatment usually go to outpatient treatment for aftercare in addition to the school recovery support program?

* Some of the responses refer to support groups rather than treatment programs.

**Majority in all models responded "no" to the following questions:**

1. Is there a family component to your prevention program?
2. Are there any problems with exchange of information between school staff and treatment staff because of confidentiality regulations?
3. Are there any special circumstances, issues or problems your school faces in providing A/D services to DASA adolescents?
4. Do you provide any P/I education for families of your students who are currently or have recently been in treatment?

# CHAPTER 7: LIMITATIONS

The School Case Study involved only four schools. The selected schools do not represent a statistical or probability sample, nor are they comprehensive in scope. It was a convenient or opportunistic selection. The study is descriptive in nature, detailing particular staffing models of SAIS in schools receiving Omnibus funds.

It was hoped that the three distinct staffing models could be found in one county so as to minimize differences of population, local economy, and geography. It was not possible to find four such schools in one county. Three of the schools are in the same county, but one of these is in a more isolated area from the other two.

All schools received Omnibus funds for the biennium 1989-1991. The funds for some of the schools in the study were cut nearly in half in the 1991-1993 biennium, making responses variable depending on the particular year in question.

In addition to representing different staffing models, the schools were recommended to be in the study because of their ongoing programs and supportive staff. Even so, staff turnover in the schools and in the assessment agencies added to the lack of knowledge of program history by some of the participants.

It was suggested that staff turnover in A/D treatment agencies is somewhat due to the fact that adolescent chemical dependency counseling is a relatively new field. Many A/D counselors get their two thousand hours of supervised training, and then move to different modalities to gain additional experience. In schools, as program funding is not always consistent from year to year, there are staff changes as people look for permanent positions.

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# APPENDICES

# CHECKLIST: MODEL ONE

(CONFIDENTIAL INFORMATION)

Name_____ Grade_____

Staff Member_____ Period_____ Date_____

**CHECK APPROPRIATE RESPONSES:**

## A: GRADES

__Lower grades/achievement
__Failure
__Falls behind in classwork
__Lack of motivation, apathy
__Cheating

## B: SCHOOL ATTENDANCE

__Absenteeism
__Tardies
__Not attending classes, but in school
__Suspension
__Frequent nurse/counselor visits

## C: PHYSICAL SYMPTOMS

__Smelling of alcohol or pot
__Glassy, bloodshot eyes
__Dark glasses
__Coordination
__Slurred speech
__Bad Headache
__Sleeping in class
__Physical complaints
__Nervousness
__Older social group
__Disorientation
__Inappropriate response/ behavior
__Depression/mood swing
__Defensive
__Withdrawn, loner
__Staggering or stumbling

## D: BEHAVIOR DISRUPTIVE

__Constant discipline
__Office referrals
__Irresponsibility, blaming, denying
__Verbal/physical abuse
__Throwing objects
__Obscene language, gestures
__Dramatic attention getting
__Crying
__Extreme negativism
__Hyperactivity

## E: BEHAVIOR ATYPICAL

__Talks freely about drugs
__Avoidance of authority figure
__Erratic behavior changes
__Viewed on day-to-day basis
__Change in peer group
__Preoccupation with drug related dress, drawing, writing
__Sitting in parking lot

## BEHAVIOR: CRIMINAL/ILLEGAL

__Suspicion of selling drugs exchanges of money
__Possession of drugs/ paraphernalia
__Involvement in thefts/assaults
__Vandalism
__Carrying weapon
__Smoking

## G: EXTRACURRICULAR ACTIVITIES

__Loss of eligibility
__Decreasing involvement
__Dropped out

## H: SOCIAL PROBLEMS

__Home problems
__Parents/guardian/ companion problems
__Runaway
__Job/Finances

## I: AREAS CHECKED IN A-H

__Represent significant changes from earlier observations of this student.

__Consistently observed. Patterns represent no significant change in behavior.

__Other (Explain Below)

MOST SIGNIFICANT BEHAVIORS: (Please Comment)_____

REFERRED BY: _____

PLEASE PLACE IN AN ENVELOPE MARKED CONFIDENTIAL AND RETURN TO_____Thank you!

# CHECKLIST: MODEL TWO

## BEHAVIORS OF CONCERN

### A: GRADES

__Lower Grades
__Erratic work habits
__Academic failure
__Always behind in class
__Lack of motivation
__Assignments not complete

### B: SCHOOL ATTENDANCE

__Absenteeism
__Often tardy
__In class some periods not others
__Suspension/Detention
__Frequent schedule changes
__Frequent counselor visits

### C: PHYSICAL SYMPTOMS

__Lack of energy
__Sleeping in class
__Glassy bloodshot eyes dark glasses
__Smelling of alcohol or pot
__Frequent trips to the bathroom
__Poor hygiene
__Staggering or stumbling
__Frequent trips to the water fountain
__Slurred speech, non-medical
__Vomiting
__Frequent physical complaints
__Frequent physical injuries

### D: POSSIBLE ILLEGAL BEHAVIOR

__Sets up deals with students
__Carries drugs or paraphernalia
__Sells drugs, money exchange
__Vandalism
__Involvement in thefts
__Assaults/physical fighting
__Carrying weapons
__Smoking on campus

### E: DISRUPTIVE BEHAVIOR

__Defiance of rules-constant discipline needed
__Irresponsibility
__Blaming or denying
__Cheating
__Fighting
__Throwing objects
__Defiant littering
__Sudden outbursts/verbal abuse
__Easily angered or upset
__Obscene language or gesture
__Dramatic attention getting
__Crying
__Constantly in wrong area
__Extreme negativism
__Hyperactivity/Nervousness

### F: ATYPICAL BEHAVIOR

__Spends time in parking lot
__Talks freely about drug use
__Avoids contact with others
__Withdrawn, loner
__Erratic behavior change from day-to-day
__Erratic mood swings
__Change of friends
__Sudden popularity
__Constant adult contact
__Older social group
__Does not like to be touched
__Sexual looseness or intimacy in public
__Time disoriented
__Unrealistic goals
__Inappropriate responses
__Depressed/talks about suicide
__Seeks adult advice without a specific problem
__Defensive

### G: OUT OF SCHOOL BEHAVIOR

__Family problems
__Runaway
__Living outside of home
__Frequent moves
__Job Problems

Other staff members report concern (Please give details)._____

Other students report concerns._____ Parents report concern.

ADDITIONAL APPROPRIATE INFORMATION (e.g. involvement with shoplifting, DWI, Court, burglary, previous referrals to Community Agencies, etc.

NAME_____ TEACHER_____

# CHECKLIST: MODEL THREE

Student's Name _____ Grade_____
Referral Date_____ Referred by_____

**PLEASE CHECK RELEVANT ITEMS**

**A: ACADEMIC PERFORMANCE**

__Decline in quality of work
__Decline in grades earned
__Incomplete work
__Work not handed in
__Failing in this subject

**B: CLASSROOM PERFORMANCE**

__Disruptive in class
__Inattentiveness
__Lack of concentration
__Lack of motivation
__Sleeping in class
__Impaired memory
__Extreme negativism
__In-school absenteeism, skipping class
__Late to class
__Defiance of authority, breaking the rules
__Frequently needs discipline
__Cheating
__Fighting
__Throwing objects
__Verbally abusive
__Obscene language, gestures
__Sudden outbursts
__Vandalism
__Frequent visits to nurse, counselor
__Frequent visits to lavatory
__Hyperactivity, nervousness

**C: OTHER BEHAVIORS**

__Erratic day-to-day behavior
__Change in friends and/or peer groups
__Sudden unexplained popularity
__Mood swings
__Seeks constant adult contact
__Seeks adult advice without a specific reason
__Time disorientation
__Apparent changes in personal values
__Depression
__Defensiveness
__Withdrawal, a loner, separate from others
__Other students express concern about a possible problem
__Fantasizing, daydreaming
__Compulsive overachievement, preoccupied with success
__Perfectionism
__Difficulty in accepting mistakes
__Rigid obedience
__Talks freely about drug use, bragging
__Associates with known drug users

**D: POSSIBLE ALCOHOL OR DRUG ABUSE-SPECIFIC BEHAVIORS**

| WITNESSED | SUSPECTED | |
|---|---|---|
| _____ | _____ | .....Selling, delivering |
| _____ | _____ | .....Possession of drug paraphernalia |
| _____ | _____ | .....Use of alcohol, drugs |
| _____ | _____ | .....Intoxication |
| _____ | _____ | .....Physical signs, symptoms |
| _____ | _____ | .....Others? |

What actions have you already taken? eg. shared concern and data with student. Initiated consequences, parent contact etc.

PLEASE WRITE COMMENTS ON THE OTHER SIDE

# CHECKLIST: MODEL FOUR

## BEHAVIOR OBSERVATION SHEET (BOS)

Student_____ Date_____ Time_____
Observer_____

This form is a report of observed behavior and all reports will be kept confidential. Please check the behaviors you have observed and give copies to _____. If you are referring for drug concerns of any kind, please give to_____.

### A: GRADES

__Not making minimum points
__Inconsistent progress
__Lack of motivation, apathy

### B: SCHOOL ATTENDANCE

__Absenteeism
__Frequently late or tardy
__Frequent use of early dismissal sign out sheet
__Frequent nurse/counselor visits

### C: CLASS INVOLVEMENT

__Participation
__Avoidance

### D: PHYSICAL SYMPTOMS

__Staggering or stumbling
__Smelling of alcohol or pot
__Vomiting
__Slurred speech
__Insubordination to staff

### E: BEHAVIOR: CRIMINAL/ILLEGAL*

__Selling drugs, exchanges of money
__Possession of drugs/paraphernalia
__Suspected involvement in thefts/assaults
__Carrying weapons
*Give one copy to Police Liaison

### F: BEHAVIOR: DISRUPTIVE

__Defiance of rules, constant discipline problem
__Irresponsibility, blaming, denying
__Verbal/physical abuse to others
__Throwing objects
__Obscene language, gestures
__Dramatic attention getting
__Frequently not in assigned area
__Extreme negativism
__Hyperactivity
__Nervousness

### G: BEHAVIOR: ATYPICAL BEHAVIOR

__Talks freely about drug use
__Bad hygiene
__Sleeping in class
__Crying
__Physical complaints
__Inappropriate responses/behavior
__Depression
__Defensive
__Withdrawn, a loner
__Erratic behavior changes as viewed on a day-to-day basis
__Cheating

### H: OTHER PROBLEM AREAS

__Family situations
__Hopelessness
__Work-related problems
__Child care problems
__Other health problems

### I: OTHER HEALTH PROBLEMS

__Other areas (please specify)

_____
_____
_____
_____
_____
_____
_____
_____

COMMENTS: _____
_____
_____
_____

## GLOSSARY OF TERMS AND ABBREVIATIONS

**AA:** Alcoholics Anonymous (Twelve Step Program)

**A/D:** Alcohol/Drug

**AFTERCARE:** Aftercare programs are designed to provide on-going support for an alcohol and drug free lifestyle as well as providing reinforcements for behavior and attitudes essential to prevent relapse and promote and maintain abstinence.

**ALCOHOL (ETHYL):** The intoxicating chemical found in liquors and produced by the action of yeast on sugars and starches often referred to as beverage alcohol, as opposed to methyl alcohol, which is not consumable and is primarily used for industrial purposes. Alcohol is a central nervous system depressant.

**ALCOHOL & DRUG ABUSE:** The use of alcohol and other drug(s) to the detriment of either the user or other members of society.

**ASSESSMENT:** A thorough individualized interview performed by a qualified or certified chemical dependency counselor to determine appropriateness for adolescent chemical dependency treatment.

**CDC:** Chemical Dependency Counselor - A counselor who has successfully completed required course work plus 2000 hours of supervised counseling as a chemical dependency counselor trainee. CDCs may be "Qualified," meaning they meet minimum regulatory standards, or "Certified," meaning they are approved by one of the three certification boards in addition to meeting minimum regulations.

**COA:** Children of alcoholics. Also refers to twelve step programs specificaly for COA's, such as Alateen.

**CORE TEAM:** Primary organizational unit of the Student Assistance Program (SAP) model at the level of the individual high school, middle school and elementary school.

**CORE TEAM MEMBER:** Any member of the school staff who consistently participates in the group discussion and referrals generated by evaluating the checklist of behaviors for changes that may indicate a student is having problems. Members have usually had some training in the signs and symptomatology of alcohol and drug abuse.

**CPS:** Child Protective Services

**DASA:** Division of Alcohol and Substance Abuse, a division within the Department of Social and Health Services of Washington State.

**DCFS:** Division of Children and Family Services of Washington State Department of Social and Health Services.

**DRUGS:** Any substance that, when ingested, changes the functioning of the body or mind. Drugs are used to treat illness, to protect against disease, to alter moods and behavior, and to promote better health. Use here typically means psychoactive drugs: ie, drugs which affect mood, cognition or behavior.

**ENABLING:** Any behavior, action or omission which allows, promotes or ignores the use of illicit drugs or alcohol by a child, adolescent, or adult.

**ESD:** Educational Service District

**INTERVENTION:** A formal response to unhealthy behavior. Intervention programs provide a healthy and effective response to an individual's or target group's substance abuse and/or other unhealthy behavior problem through awareness, identification, and planning.

**NA:** Narcotics Anonymous (Twelve Step Program)

**OMNIBUS DRUG ACT:** Washington State alcohol and Controlled Substances Act: Prevention and Intervention Services Program of 1989 (RCW 28A.170.-075-100.)

**OMNIBUS DRUG FUNDS:** Money available from the Omnibus Drug Act.

**OSPI:** Office of Superintendent of Public Instruction

**PREVENTION:** Keeping people healthy, and assisting high risk individuals to lower their risk. Prevention programs will reduce substance abuse problems and enhance the likelihood of healthy lifestyles by helping people acquire information and develop social skills, personal resources, and emotional support.

**RAP:** Recovery Assistance Program, an aftercare curriculum used in some schools.

**RE-ENTRY:** Re-entering or returning to school after an absence due to A/D treatment.

**RECOVERY SUPPORT:** See Aftercare.

**REFERRAL:** Finding help for unhealthy behavior. Referral programs include following procedures to access appropriate resources for use by individuals or target groups when addressing identified problems.

**SAP:** Student Assistance Program - Programs that attempt to address some of the special needs of students in schools relating to problems of alcohol/drug use.

**SAPS:** Student Assistance Program Specialist

**STAFFING:** A meeting of staff members, such as the clinical director, A/D counselor, dietician, and teacher, to map out a treatment plan for an individual client. It is desirable to have parent(s) and school representative at a staffing.

**TREATMENT CENTER/AGENCY:** Any center/agency certified to administer chemical dependency treatment.

# METHODS

## Selection of Staff for Interviews

Staff, both in schools and assessment agencies, involved in the referral of students who may have a drug or alcohol related problem, are the key players interviewed in the school case study. The focus was on interviewing those who were directly involved in the referral, prevention or intervention process (see Table 3).

A presentation of the proposed study was made to the Adolescent Project Advisory Committee. Many suggestions as to whom to interview came from this group. Suggestions of those to interview included: Educational Service District (ESD) alcohol/drug (A/D) coordinator, school district A/D coordinator, school principal, school psychologist, school nurse, Prevention/Intervention Specialist, core team member, teachers, school counselor, special services director, assessment/treatment personnel, agency administrator, parents and students (those in Natural Helpers, student government, etc.).

Due to the additional requirements involved in contacting parents or students in school, it was agreed that neither would be interviewed. Not all schools had nurses or psychologists on staff. Some districts contracted for these services on a part-time basis, sharing the time with other schools or districts. In districts that did contract for psychological services, the psychologist was not involved in the alcohol/drug referral or assessment process. In the school with a psychologist on staff, the psychologist stated that he was not involved in the prevention/intervention programs nor the core team activities.

## Selection of Staffing Models and Schools

In talking with staff from the Office of the Superintendent of Public Instruction (OSPI) and treatment agencies, three main staffing models for Intervention Specialists were identified as operating in schools receiving Omnibus Drug funds. The intent was to look at these three staffing models in various locations within a regional area. This would have minimized costs and regional variations. Not all models were available in the same region. Two models are from the same county; one model studied is in Eastern Washington. Schools were chosen primarily by staffing model, but also by area (urban, rural, or sub-urban setting), and school size (large, medium, small and alternative). An alternative school was included in the cases studied because of the special population they generally serve. All schools received Omnibus drug funds and are in the third year of their programs. Though all schools have been in the program the same length of time, some of the grant amounts have changed, and this is affecting the current biennium programs.

**TABLE 3: STAFF INTERVIEWED AT VARIOUS MODELS**

| INTERVIEWED | MODEL 1 | MODEL 2 | MODEL 3 | MODEL 4 |
|---|---|---|---|---|
| Principal | X | X | | X |
| Vice-Principal | | | X | |
| Counselor | | | X | X |
| Counselor/Substance Abuse Intervention Specialist | | X, X | | |
| SAIS (School hired CDC, assessments on campus) | X | | | |
| SAIS (Agency contracted CDC, assessments on campus) | | | X | X |
| Agency contracted CDC (Assessments off-campus) | | X | | |
| Student Assistance Specialist | | | X | |
| Counselor/Teacher Core Team Member | X | | | |
| Teacher/Core Team Member | | X | X | |
| Teacher | | | | X |
| School Nurse | | | X | |
| Faculty Aide Core Team Member | | X | | |

Because alcohol and drug prevention and intervention programs require time to be established, and for the Intervention Specialist to develop trust and relationships among the students, it was thought important to know the drop-out rate in the schools. A high drop-out rate would indicate less continuity of program knowledge by students from year to year.

Mobility rates and withdrawal rates are kept by schools. Mobility refers to those students who move from one school to another within the school district. For example, a student may go to the alternative school for one semester, and then go back to his regular school. This move would be reflected in the mobility rate as would the move of a student whose family moved to a home in a different school boundary, but within the same district. Withdrawals are all other moves. They include moves to another district or out of state, and leaving school for other reasons such as poor grades, high absenteeism, work, pregnancy, not liking school, etc. (see Table 4).

Structure of Interviews

In developing the questionnaire, input from various sources was sought. Draft copies went to A/D counselors, school counselors, treatment administrators, OSPI staff, ESD staff, school board members and DASA headquarters and regional administrators. Suggestions were incorporated into the final instrument.

This study was non-experimental and unobtrusive. The interviewer was not a participant in any of the core team meetings or assessments. Most of those interviewed had been at their respective schools a number of years and had participated in the Omnibus funded program the prior two years. Varied perspectives were obtained by asking the same questions of each participant.

Most questions were structured to be close-ended (25%) or partially close-ended (40%) to be expeditious. Thirty percent of the questions were open-ended usually to solicit a response as to what has been more effective or less effective in a particular process. At the end of each section, questions asking for an overall rating were close-ended with ordered answer choices (4%) [excellent, very good, good, fair, poor.] Each section ended with an open-ended question for additional comments the participant may have had. The four main sections of the questionnaire are:

(1) Referrals

(2) Assessments

(3) Treatment

(4) Re-entry

## TABLE 4: POPULATION DATA AND WITHDRAWAL/MOBILITY RATES

| CATEGORY | MODEL 1 | MODEL 2 | MODEL 3 | MODEL 4 |
|---|---|---|---|---|
| *Standard Metropolitan Statistical Area | N/A | 189,000 | 586,000 | 586,000 |
| % Increase '80 - '90 | - | 9.5% | 20.7% | 20.7% |
| City Population | 2,240 | 5,100 | 177,500 | 177,500 |
| % Increase '80 - '90 | 25% | 11.8% | 10% | 10% |
| Estimated School District Boundary Population | 4,750 | 20,000 | 177,500 | 177,500 |
| School DISTRICT Student Population | 1,406 | 3,100 | 30,775 | 30,775 |
| **Relative Population of School | 1.25 | 2.8 | 4 | 1 |
| **Relative Size of Staff | 1.13 | 2.7 | 5 | 1 |
| +Withdrawal Rate | 6% | 3% | 11% | +++ |
| ++Mobility Rate | 17% | 12% | 15% | +++ |

* SMSA information from the Office of Financial Management, Washington State, 1991 Data Book.

** For anonymity relative population of school and size of staff are used, one model relative in size to another, with the smallest, Model 4, represented by 1.

+ Withdrawal Rate: Refers to students who do not transfer to another school within the district or area, but leave school for some other reason such as grades, excessive absences or work.

++ Mobility Rate: Refers to students who transfer to another school within the district or, in small districts, to a district near-by.

+++ Alternative schools have a high turnover rate. One hundred thirty-five percent of the students in this school stayed five months or less. The school actually enrolled over twice the average number of students during the school year ('89 - '90 school year statistics).

The same questions were asked of each participant. Topics were organized to follow the general referral process of a student in need of A/D treatment. The results of this referral process may result in an assessment, treatment and re-entry to school. Questions were asked in the following areas:

(1) The participant's general knowledge of A/D treatment programs in the community,

(2) The referral process within the school,

(3) The process of a student receiving an assessment,

(4) The process of a student receiving treatment, and

(5) The students' re-entry to school.

Participants were interviewed individually, mostly during their scheduled planning period. Individual questioning was done to verify answers within a particular school, to access different actors, and to find out who had what information. An example of this is that the administrator is generally more knowledgeable about budget related matters, for example program funding, and the assessment person more knowledgeable about treatment agencies. Actors within the same school basically answered the same questions in a similar way. This increased our confidence in the reliability of the information obtained. Questions answered by "don't know," were generally followed by a statement of who did know or who did have the information. This indicates a clear delineation and understanding of responsibilities among the staff.

Manner of Interviews

Most of those interviewed were employees of school districts. District Administrators stated that intervention programs are in the schools because alcohol and drug use interfere with the educational progress of the student. The effectiveness of intervention programs in any school was directly related to the support for the program by the school administrator. It is believed that there is a high reliability rate in the information given by staff. One person may have had more precise information in his or her area of expertise, but it was not contradictory to others. Parents and students were not contacted in this study.

It was the intent to keep the interview to approximately fifty minutes to stay within the time frame of most school periods. The interviews were usually over one hour in length, requiring additional scheduling or phone calls to complete. In nearly all cases interruptions occurred. (This is as one would expect, with people in these positions.)

The schools in the case study were recommended because of their ongoing programs and supportive staff. Each school had a list of behaviors staff could refer to in observing the students. Core team members had additional training in the characteristics of adolescents abusing drugs. One key question to estimate how well the referral system worked was one that asked how many times the student meets with a teacher or counselor before being referred to

the intervention specialist. At most the answer was one. Usually the answer was none.

Once a notice of change in behavior was observed in a student, a referral was made to the intervention specialist - usually in person or with a confidential note. Check lists are distributed to the student's contact teachers and a confidential observation is done. Check lists are collected and evaluated by the core team with the referring person in attendance. It is at this time that a decision is made about the I/S meeting with the student.

Most Intervention Specialists work with a myriad of issues, so that a student need not expect concern about drug/alcohol use when called in by the I/S. If there was an A/D concern, assessments were most often done right away or an appointment for an assessment was made at this initial meeting.

Contact with parents and plans for treatment were often discussed at this initial meeting if assessment showed A/D abuse or addiction. At all schools in the study there seemed to be a clear process of referral, assessment, treatment and re-entry. There was contact with the student while in treatment for academic work and re-entry scheduling, though not as much as the school staff would like, due primarily to time constraints.

The four schools in this case study represent P/I programs known to be among the state's strong P/I programs. Staff tasks seemed to be clearly defined. Though the interviews were longer than originally planned, everyone was most cooperative in scheduling time to complete the questionnaires. The open-ended questions allowed for a substantial amount of comments by some of the participants.

# STUDENT ASSISTANCE PROGRAM (SAP)

Based on language contained in the Omnibus Act of 1989, the intervention specialist could include any combination of the following activities in their comprehensive SAP: (Office of the Superintendent of Public Instruction, 1991, March).

- Individual and family counseling, including preventive counseling.
- Assessment and referral for treatment.
- Referral to peer support group.
- Aftercare.
- Development and supervision of student mentor programs.
- Staff training, including the identification of high-risk children and how to work with the children in the classroom.
- Development and coordination of the "core" teams (involving staff, students, parents, and community members).

The specific services provided in the several student assistance programs established as a result if the OSPI grant program have naturally varied from site to site. Variations in programs have resulted from the following factors:

- Size of school;
- Number and location of community resources;
- Previous alcohol/drug abuse and intervention education received by school staff, administrators, and teachers;
- Existence of an established/trained "core" team that serves as an intervention focal point;
- Availability of "support networks" in the family, and community to strengthen the after treatment support provided in the school; and
- The level of acceptance or denial of alcohol/drug abuse problems among youth by school personnel and the community.

# TREATMENT CENTER SAMPLE LETTER TO SCHOOLS

Date

Address

RE:
DOB:

Dear

_____ has entered a treatment program for chemical dependency at (name of treatment center). His/Her primary counselor will be _____. To better assist us in designing a treatment plan we would appreciate any records regarding his/her academic, psychological, medical, legal, chemical use and/or disciplinary history. Your prompt response to this request would greatly enhance the treatment process. Enclosed you will find a signed consent for the release of confidential information for this purpose.

We will attempt telephone contact within the first three days after admission. If you have not been contacted yet then please contact me at (phone number).

We welcome you to participate in our Wednesday staffings. Please contact the patient's primary counselor to make arrangements. Letters to patients are welcome and encouraged. Thank you for your _____.

**TO EXPEDITE THIS EXCHANGE OF INFORMATION, PLEASE FAX ANY INFORMATION YOU MAY HAVE IF A MACHINE IS AVAILABLE. OUR FAX NUMBER IS (FAX Number).**

Sincerely,

(Name)
Adolescent Admission/Assessment Counselor

Enclosure